SERIOUS CASE REVIEW
FAMILY U

Independent Author: Sian Griffiths
Date: July 2018.
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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 with parental agreement\(^1\), made disclosures that she and three of her siblings had been seriously sexually abused by her father. Her older sister, Sibling 1, was already in a foster placement. The two younger children, Sibling 3 and Sibling 4, were removed under powers of Police Protection and placed in foster care. Care Proceedings were initiated in relation to the four children all of whom were made subject to Care Orders in January 2016.

1.1.2 The parents were both arrested and charged with a number of offences. The father pleaded guilty to a large number of offences of rape and sexual assault of a child under 13 relating to 6 victims. He received a life sentence with a minimum tariff of 16 years. The mother pleaded guilty to an offence of child maltreatment under Section 1(1) of the Children and Young People’s Act 1933. The mother was sentenced to 2 years imprisonment. An older Sibling pleaded guilty to Sexual Activity with a Child Family Member and received a 2-year Suspended Sentence with a Supervision Order.

1.1.3 The case of Family U was referred to the Serious Case Review Sub Group of the Norfolk Safeguarding Children Board on 26th October 2015 by Norfolk Constabulary. At this point the SCR Sub Group concluded that it was not in a position to make a decision until the Criminal and Care Proceedings were concluded in early 2016. The SCR Sub Group met again in April 2016 and recommended that the case had met the criteria for a Serious Case Review as identified in Working Together to Safeguard Children 2015\(^2\), in that there was information that:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

The Independent Chair of Norfolk Safeguarding Children Board formally made a decision to undertake a Serious Case Review on 11th April 2016. The National Panel was notified the following week and the Independent Reviewer was also identified at that point.

1.1.4 Due to complex criminal investigations and proceedings involving 3 family members which were not completed until January 2018, the Review was unable to be completed until March 2018.

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\(^1\) Section 20 of the Children Act: provision for a child in need to be accommodated by the Local Authority with the consent of the parents or others with parental responsibility.

\(^2\) Working Together: HM Govt 2015
1.2 Family Composition

The family members referred to in this review are as follows:

<table>
<thead>
<tr>
<th>IDENTIFIER</th>
<th>Relationship</th>
<th>Born</th>
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<tbody>
<tr>
<td>Children</td>
<td></td>
<td></td>
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<tr>
<td>subject of</td>
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<tr>
<td>the SCR</td>
<td></td>
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</tr>
<tr>
<td>Sibling 1</td>
<td>Child of mother and previous partner</td>
<td>2001</td>
</tr>
<tr>
<td>Sibling 2</td>
<td>Child of mother and father</td>
<td>2004</td>
</tr>
<tr>
<td>Sibling 3</td>
<td>Child of mother and father</td>
<td>2006</td>
</tr>
<tr>
<td>Sibling 4</td>
<td>Child of mother and father</td>
<td>2007</td>
</tr>
<tr>
<td>Mother</td>
<td>Mother of the children under review</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>Father of Siblings 2,3,4</td>
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<tr>
<td>Older Sibling</td>
<td>Older Brother</td>
<td>1994</td>
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1.3 Methodology

1.3.1. Statutory guidance within Working Together requires Local Safeguarding Children Boards to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews. The guidance establishes the purpose as follows:

*Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.* (Working Together, 2015:73)

1.3.2. The statutory guidance requires reviews to consider: “*what happened in a case, and why, and what action will be taken*”. In particular, case reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
1.3.3. The methodology used for this Review was underpinned by the principles outlined in Working Together 2015, including the need to use a systems approach. The author of this report is familiar with a systems based methodology. In particular this approach recognises the limitations inherent in simply identifying what may have gone wrong and who might be ‘to blame’. Instead it is intended to identify which factors in the wider work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. A central purpose therefore is to move beyond the individual case to a greater understanding of safeguarding practice more widely.

1.3.4. The Review was led and authored by Sian Griffiths who is independent of all the agencies involved. Sian Griffiths has significant experience in undertaking Serious Case Reviews. A second Independent Reviewer, Bridget Griffin, was commissioned for a limited number of days to provide additional capacity including offering a quality assurance role, given the complexity of the case.

1.3.5. The Independent Reviewer worked with a core Review Team from relevant agencies in Norfolk. The Review Team was made up of Senior Safeguarding representatives from the following agencies:

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<th>TITLE</th>
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<tbody>
<tr>
<td>Head of Quality and Effectiveness</td>
<td>Norfolk County Council, Children’s Services</td>
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<tr>
<td>Education Advisor</td>
<td>Norfolk County Council, Children’s Services</td>
</tr>
<tr>
<td>Named GP</td>
<td>Great Yarmouth and Waveney Clinical Commissioning Group</td>
</tr>
<tr>
<td>Police Inspector</td>
<td>Norfolk Constabulary</td>
</tr>
<tr>
<td>Named Nurse for Safeguarding Children</td>
<td>Norfolk and Norwich University Hospital NHS Trust</td>
</tr>
<tr>
<td>Norfolk Community Health and Care NHS Trust</td>
<td>Safeguarding Lead</td>
</tr>
<tr>
<td>Norfolk Community Health and Care NHS Trust</td>
<td>Deputy Named Nurse</td>
</tr>
<tr>
<td>Norwich City Council</td>
<td>Head of Neighbourhood Housing Services</td>
</tr>
<tr>
<td>Norfolk Suffolk NHS Foundation Trust</td>
<td>Specialist Safeguarding Practitioner</td>
</tr>
<tr>
<td>Cambridgeshire Services NHS Trust</td>
<td>Community Safeguarding Lead</td>
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<td></td>
<td>Designated Nurse -Safeguarding</td>
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The Norfolk Safeguarding Children Board Manager was also a member of the Review team and the Board provided administrative support.

3 HM Govt, Working Together (2015:74)
The Review Team met on 6 occasions.

1.3.6. The review process included the production of chronologies and succinct Agency Reports produced by the following 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)

A shorter chronology was also provided by CAFCASS.

A full check was made across the voluntary and statutory sector and several organisations who were identified as having contact with the family in the time period under consideration were asked to check records and provide any information. Many of these agencies had limited information to contribute or had not retained information given the passage of time and change of roles or commissions. However, some further specific information was provided as a result.

1.3.7. A range of primary documentation was made available to the Review including:

- Specific extracts of records from Children’s Services
- Records from Norfolk Housing Families Unit
- Summary Psychological Assessment in relation to Care Proceedings.
- Legal department chronology
- CAF records

1.3.8. The Independent Lead Reviewer and members of the Review team undertook a wide range of meetings with individual professionals who had direct involvement with key members of the family. A total of 24 professionals, from across the key agencies took part in individual meetings, providing a significant amount of information regarding their involvement with the family.

1.3.9. Towards the end of the process a full day event took place involving the review team and the majority of the key professionals who had been seen individually. The purpose of this event was to maximise factual accuracy as well as for the professionals concerned to contribute to the analysis and future learning.

1.3.10. The **timeframe** under consideration for this Review was:

**January 2005 – October 2015**
The four children subject to this review were part of a larger sibling group, most of whom at during the prime period under consideration were living independently. Information available to the Review suggested that some of the older siblings may also have experienced problems as children. Whilst it was considered disproportionate to consider the 10-year period in full detail, it was agreed that there should be some consideration of the family's earlier years to identify if there might be learning which would not otherwise be identified.

1.3.11. It was therefore agreed to consider the time period in three parts:

i. **2005 – 2011**: The review of this period would entail an analysis of the chronology and identification of any significant learning that did not emerge within the primary period for consideration.

ii. **January 2012-October 2015**: Primary period for consideration

iii. **October 2015 to April 2016**: Consideration only to be given to any significant issues of multi-agency working, immediately post disclosure.

1.3.12. The Review was asked to take into account any learning gained recently from previous Serious Case Reviews. The focus would be to identify further learning, or the degree to which previously identified learning had been translated into practice. The Terms of Reference identified four particular issues for consideration by each agency within the Review, however these were not intended to limit any other learning that might emerge:

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?**

The Serious Case Review was also asked to take into account the NSCB’s Thematic Learning Framework (see Appendix B).
1.4 Contribution of family members

1.4.1. The involvement of key family members in a Review can provide particularly helpful insights into the experience of receiving or seeking services. Careful consideration was given to informing and involving key family members given the highly sensitive nature of this case, the long-term impact on the four children and their older siblings of what had taken place and the impact of the ongoing criminal proceedings.

1.4.2. The mother and father were informed by letter at the outset that the Review would be taking place. Following the completion of criminal proceedings, they were again contacted to see if they would be willing to meet with the Independent Reviewer to provide their views. The Independent Author and the NSCB Board Manager met separately with the mother and maternal grandmother. The father did not respond to the offer of a meeting. The children’s older siblings were also informed and later asked if they were willing to take part but did not respond to attempts to contact them.

1.4.3. Advice was taken from social work staff in relation to informing the four children subject to this Review that it was taking place and then asking if they would want to meet and contribute to the report. Sibling 1 and Sibling 2 both met with the Independent Reviewer and the Board Manager. Sibling 3 decided not to attend a meeting. Sibling 4’s Social Worker advised that Sibling 4 would not be able to undertake such a meeting at this stage. Nevertheless, she was informed that her siblings would be contributing to the Review.

1.4.4. Each of the family members contributions are summarised in Section 4 and as relevant are also included in the analysis at Section 5.

1.4.5. The author would like to thank all the family members who contributed to this Review. Particular thanks go to Sibling 1 and Sibling 2 for their strength of character and courage in being willing to talk about their experiences. Their contribution will best be repaid by agencies and professionals taking action to better help children in the future.

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

The following is a chronological summary of what is now known about the family and their involvement with agencies. The summary, as far as is possible, will identify what was, or was not, known to the relevant agencies at the time the events were taking place. It should be noted that although the summary has been significantly condensed from all the available information, it nevertheless remains quite lengthy, and reflects a complex family story. A conscious decision was made to include it in this way so as to effectively reflect the complexity of agency involvement as it would have been experienced both by the children and by professionals themselves.
Section 1: Early years 2005 - 2011

i. This first section consists of a summary of the relevant information known about the family and the involvement of services with the family prior to 2012.

ii. At the beginning of 2005 the family was composed of the mother and father, the older siblings, who were children of mother’s previous partners, and Sibling 2, the first child of the mother and father. It is not known whether all the older siblings were living in the household. Sibling 3 was subsequently born in 2006 and Sibling 4 in 2007. It is understood that the father did not have Parental Responsibility for the children.

iii. The school age children were all in local schools, although there were problems regarding attendance and behavioural concerns particularly with Older Sibling. There were a range of problems and concerns regarding each of the children, including direct allegations and disclosures of sexual abuse. A number of services were involved with members of the family and had different levels of knowledge of these concerns. There was a pattern of the mother not attending appointments.

iv. The father was being treated throughout this period for depression linked to his own experience of abuse by his father when he was a child. There were increasing references to his anger. Although he was referred to the Mental Health Trust, he was eventually discharged due to non-engagement. The father had a significant level of involvement with Health Services as a result of his depression. The mother also had significant physical health problems and had a high level of contact with Health Services as a result.

v. Between 2005 and 2011 there were at least 7 referrals made to the Police and Children’s Services regarding the children. These included referrals as a result of two of the older children going missing, as well as concerns about the conditions in the home. On one occasion in 2008 Children’s Services completed an Initial Assessment and a referral was then made to Homestart. One of the older siblings was referred for a mental health assessment following an overdose, and two had young pregnancies, with their children becoming subject to referrals and assessment by Children’s Services.

vi. CAMHS were working with Older Sibling as a result of anger management, with particular concerns about his behaviour with his sister. He had been identified by a psychologist in 2006 as suffering from anger, anxiety, PTSD and ADHD.

vii. On several occasions referrals both from professionals and neighbours related to allegations of either inappropriate sexual behaviour by adults towards children, or more directly that sexual abuse had taken place. This information came from the children themselves using explicit language and description.

viii. On one occasion a relative of Older Sibling, who lived in a different family, told her teacher that she had been sexually assaulted by him. Strategy discussions and Police investigations were initiated but did not lead to further action being taken. The reasons for not taking action included the child not making a disclosure to the Police in interview and alternative explanations being provided.
by the mother. The allegation was not felt by the Police to be credible and her ‘limited intelligence’ was noted as a feature of the assessment.

ix. On another occasion in 2006 there was an allegation both that 5-year-old Sibling 1 had been made to drink washing up liquid by the father, but also that she seemed to have been made to perform sexual acts. The father was required by Children’s Services to leave the house temporarily in order to resolve his mental health problems and was assessed by a mental health practitioner. After 6 months he returned home with no further assessment by Children's Services. Separately, another police force sought and shared intelligence about the father ‘regarding sexual abuse issues’ relating to his birth family with Norfolk Police.

x. The school noted continuing concerns about Sibling 1, who was frequently described as having a lot of worries about her family, including that her brother was physically abusive to her, also describing him as a pervert. The mother produced a log of her behaviour which she gave to the school. There were increasing references to Sibling 2’s ‘problematic behaviour’, including physical aggression and signs of emotional distress. This led to the GP referring Sibling 2 to the Mental Health team, who informed her she should refer to the Community Paediatrician instead for assessment. The Community Paediatrician had concerns about Sibling 2’s presentation and requested health visitor follow up with the possibility of clinical psychology involvement in the absence of any improvement. In October 2011, following a referral to the specialist ADHD nurse, the Consultant Paediatrician diagnosed Sibling 2 as having mixed neurodevelopmental problems and ADHD.

xi. The three youngest children, Sibling 2, Sibling 3 and Sibling 4, all gave some cause for concern to health services from an early stage due to home conditions, and developmental delay. All three had speech and language difficulties involving the SALT service. There were also a small number of occasions when there were potentially concerning bruises or injuries to the children, although explanations were given for these and accepted. Each of the three girls was presented to the services by their parents as having worsening behavioural problems. In 2011 an Educational Psychologist recommended the school develop an Individual Education Plan for Sibling 4 and for a few months a CAF[^4] was put in place and led by the school.

Section 2. The Primary period under analysis
January 2012 – Oct 2015

I. 2012-Summer 2013: School Concerns and a CAF is put in place.

i. At the beginning of 2012, Older Sibling was enrolled at college part time and had been re-referred to CAMHs by his GP for anger management problems, this service worked with him until the summer. Sibling 2 continued to be

[^4]: The CAF is a shared assessment and planning framework that was used when it was assessed that child had additional needs, to identify those needs and co-ordinate services to meet the needs. This has been replaced in Norfolk by the Family Support Process.
reviewed by the Community Paediatrics team. Her behaviour was described as deteriorating and aggressive by her mother and grandmother, who were keen for her to receive further medication. Sibling 4 had also been identified as having significant learning difficulties as well as social, emotional and behavioural difficulties. A statutory statement regarding her educational needs was requested and she was also being seen by the SALT team (Speech and Language Therapy). There were ongoing concerns regarding Sibling 1’s school attendance. A referral was made to the School Attendance Service who worked with the family and it was subsequently agreed that no legal action would take place due to improved attendance. Mother and Father were separated but there continued to be contact between father and the children.

ii. In February 2012, a girl at Older Sibling’s school told a pastoral support worker that he had sexually assaulted her. This was reported to the Police, but no further action taken as the girl and her mother did not want to make a formal complaint. The police referred this to Children’s Services, but there is no information as to whether any further action was taken.

iii. In April 2012, the CAF which had been closed in October 2011 was reopened and the family was said to be working with the Families Unit, part of the Housing Department at Norwich City Council, in relation both to school attendance and home conditions. Sibling 2’s aggressive behaviour at home was of concern.

iv. During May 2012, there were two issues of concern in relation to Sibling 1 who was 10 years old. Firstly, she was heard by a teacher talking about sex in a way which caused concern. A few days later she told a teacher that she had been raped by a 14-year-old boy some months previously. The school contacted the Police and made a referral to CSC. Sibling 1 subsequently told the Police that she had lied, and as a result no further action was taken by the Police other than forwarding a routine notification, known as a C39d, to Children’s Services. This was discussed at the CAF meeting and the GP was then asked to make a referral to CAMHS. The GP who saw Sibling 1 identified the concerns as a child protection issue and contacted Children’s Services. A duty team Social Worker visited the home and was told by the mother that the alleged rape could not have taken place. The mother agreed to a referral to the school nurse and Families Unit, although there is no evidence that the referral was received. An Initial Assessment was subsequently completed and concluded that no further action was required as the family was engaging with the CAF.

v. From this time onwards these behavioural and presentational difficulties, as well as school attendance, continued to be a problem for all the children. The mother provided a range of explanations as to why she was unable to get the children into school, primarily that Sibling 2’s behaviour was the cause of the family’s difficulties. On one occasion, Sibling 4 was seen at school to have finger-tip bruising apparently caused by Sibling 2. This was again noted by school as a Record of Concern and referred to Children’s Services, who stated it was already an open case. Both the family and the professionals who were part of the CAF appeared to be unclear as to the role of Children’s Services at this time. The CAF notes stated again that a referral to the Families Unit would be made.
vi. During the summer the mother was admitted to hospital with serious health problems. It was recorded at the CAF that the father and maternal grandmother were taking care of the children in her absence. There was other information around this time that the Mother had gone to visit her ‘boyfriend’, leaving the children with an older sibling and providing no means of contacting her. The mother’s health problems continue to be managed by the GP and are frequently referred to over the period covered by this Review.

vii. Following the school summer holidays, the children’s problems continued as before and CAF meetings recommenced. A mixed picture was provided to professionals of the father’s involvement. On the one hand, he was said to settle Sibling 2 in bed at night before going back to his own home, on the other hand the mother told the GP that the father provided little help. The GP records note an intention to speak to the Social Worker involved, but there is no further information. As the mother was now very immobile, an arrangement was made for her to be provided with a hospital bed in the front room and for her to be provided with a wheelchair.

viii. One of the concerns identified by the school was that Sibling 2 often made inappropriate personal comments to both teachers and other children. This was a feature of her behaviour which was noted on a number of occasions. Later in the year 11-year-old Sibling 1 was taken by her grandmother to see the GP as she was self-harming and talking about ending her life, this was said to be linked to bullying by her brother as well as others in school. The GP made a referral to CAMHS asking that Sibling 1 be assessed and also made a referral to Children’s Services. A CAMHS practitioner concluded that Sibling 1 did not have any mental illness. She was however offered counselling by Family Solutions, part of the CAMHS service, but did not want to take this up.

ix. A further Initial Assessment was undertaken by Children’s Services in December 2012 after Sibling 1 was reported missing and then made allegations of being threatened and bullied by other children. Sibling 1 had also written in her diary about wanting to hurt herself and about ending her life. Again, she eventually said that she had invented the allegations of being bullied and threatened but could only explain that she would like more attention from her mother. The house was described as ‘dirty and in a state of chaos’. The assessment concluded that the family were working with the CAF and there was no role for Children’s Services. At the end of the year the school records state they made another referral to the Families Unit identifying the family’s biggest concerns as being Sibling 2’s extremely challenging behaviour and Sibling 1 being bullied. This was however the first referral that is known to have been received by the Families Unit.

x. In the Autumn of 2012 the father had also referred himself back to the mental health wellbeing service for counselling and had his first appointment in December. He is recorded as being treated for depression and anxiety by his GP and seeing his three children during the week.

xi. The Families Unit began working with the family in January 2013 and their primary role was to help the family maintain their tenancy. Two workers were allocated, and they worked consistently with the family until the case was closed.
in November 2013. The practitioners identified a wide range of needs and actions, from arranging for garden clearance, to helping with school attendance, to providing support to several of the family members, particularly Sibling 1, who was identified as having needs in relation to identity and emotional wellbeing.

xii. The Families Unit Practitioners recorded that Sibling 1 behaved in an inappropriately sexualised way and that both Sibling 2 and Sibling 3 were overfamiliar with them. Older Sibling was also identified as having serious anger problems, including assaulting Sibling 1. The staff from the Families Unit visited on a very regular basis over the following months, spending time with all the siblings including Older Sibling, helping with morning routines, liaising closely with school and taking Sibling 1 to school. The parents had been given a place on a parenting course run by the school which had first been agreed over a year previously. However, neither parent actually attended. CAF meetings continued, and included the school, Families Unit, the mother, maternal grandmother and Older Sibling.

xiii. A range of professionals continued to be involved with the family and other referrals were also made to organisations but were not taken up by the parents. This pattern continued throughout the time period under consideration.

xiv. In early 2013 the mother was recorded by Children’s Services as planning to ‘trial alternate nights away from the family home for respite’ with other family members working collaboratively to provide care. It is not clear what Children’s Services’ involvement was at this time and how, or if, this arrangement was assessed. In March, the Ambulance Service informed the Police of a disturbance when Sibling 1 was said to have kicked her grandmother. This led to the Police informing Children’s Services but there is no information as to what action, if any, was taken by them as a result. Around the same time the Schools Attendance Service concluded that it should proceed to a prosecution in relation to Sibling 1 and the Mother in due course was prosecuted and fined.

xv. Older Sibling was identified as struggling with depression and anger. One of the practitioners from the Families Unit took him to see his GP who arranged for another referral to the Mental Health Wellbeing team.

xvi. Sibling 1 went missing from home on 2 further occasions in 2013 but was found and returned by the police who informed Children’s Services using the agreed C39d form. After one of these occasions a manager at the MASH referred it to the Duty Team for another Initial Assessment. A referral had also been made by the Families Unit a few weeks earlier, but the outcome of this had been that they were told the CAF was a satisfactory way of working with the family.

xvii. The Initial Assessment was allocated 6 weeks after it was referred to the Duty Team and completed a further two months later in July 2013. By this point there were numerous continuing concerns being identified by the school and Families Unit, including:

- Renewed court action regarding Sibling 1’s school attendance
- Mother’s physical health and the impact on the children;
- The emotional health of both parents;
• Mother going away at weekends to visit her boyfriend some distance away, leaving the children with the father who was said to ‘struggle to cope’, including having been seen ‘pushing Sibling 2 against a wall’.
• Conditions in the home;
• The quality of parenting and lack of progress or improvements.
• Sibling 2 suffering from bedwetting, and a bruise on her cheek after ‘falling on her bed’
• Police called by a neighbour who heard screaming and shouting – explained by mother as Sibling 2 having a tantrum.
• Sibling 4 withdrawn, very emotional and ‘often looks very sad.’

xviii. The Families Unit practitioner had also recorded concerns about the risks to Sibling 1 of sexual exploitation and spoken to the mother about it. During an individual session with this practitioner, Sibling 1 said that she had something she wanted to share but would not say any more. As a result of this the Families Unit practitioner spoke to her manager and made a further referral to Children’s Services. They had also made a referral to Adult Social Care for a community care assessment in relation to the mother, but she declined the support they offered.

xix. The Families Unit also referred Older Sibling to Norfolk Carers Support, however the service was unable to engage with him and eventually closed their involvement. The Father had been offered contact with the Wellbeing Service including a place on a Stress Control group. However, he did not respond to their attempts to make contact, despite continuing to present at the GP with the same problems, and the Wellbeing Service closed the case. Sibling 2 was re-referred to the ADHD nurses by the Community Paediatrician following her mother raising further concerns about her aggression.

II. July 2013 – March 2014 Child in Need Plan put in place

i. The outcome of the Initial Assessment was that the children were transferred to the Child in Need team in July 2013

ii. Between late August and the end of 2013, the Police were called out on 6 occasions in relation to incidents involving Sibling 2. On the first occasion, they were called by a neighbour who described seeing the father responding badly to Sibling 2, who was distressed and trying to run away. The Police were told that the incident was triggered when the father came to collect two of the children to stay with him for the night. Other occasions involved Sibling 2 being said to be in violent rages, including times when her mother restrained her. The mother stated she had numerous injuries as a result of needing to restrain Sibling 2 and school staff also recorded the mother being assaulted by Sibling 2. On one occasion Sibling 1 called the Police, who also noted the house to be damp and smelly. All of these events were referred to Children’s Services.

iii. At the beginning of October 2013, a Social Worker from the Child in Need (CIN) team was allocated to the family and the first CIN meeting took place. The focus was initially on neglect with Sibling 1, but soon included Sibling 2 who was also now refusing to go to school. The Social Worker at this point made referrals to
the Children’s Services Targeted Support Team, Home Based Support\textsuperscript{5} and Starfish, the children’s Learning Disabilities service run by NCHC. The Housing Families Unit initially continued to visit 2 or 3 times a week but ended their work in November 2013 due to the recent involvement of CSC and the lack of progress.

iv. In November, the Social Worker visited the father at his home. It is recorded that he had not been allowed to have weekend contact with the children following the earlier incident when the Police were called. He was however visiting the home twice a week. It is not clear who was responsible for this decision to place restrictions on the father’s involvement with his children. The result of the Social Worker’s visit was in any event that contact would continue to be supervised until the father had a ‘mental health assessment’.

v. By late November 2013 Sibling 1’s school attendance was recorded as being less than 5%. It was agreed that she should attend for the afternoons as part of the School Inclusion Project, that Home Based Support would support her school attendance but also that the local Authority would commence legal proceedings for her non-school attendance. The involvement of Home Based Support lasted for just three weeks when it was concluded that it was insufficient for the family’s needs. A recommendation was also made in the Child in Need action plan that Sibling 1 be found a residential school placement from Monday to Friday.

vi. Both the Social Worker and the Home-Based Support care worker were concerned about the apparent violence in the home from Sibling 2, in particular towards her mother. On one occasion in December the Police were called out, and requested a home visit by Children’s Services. The Police recorded “\textit{a real risk of further harm to the mother…..also a risk to the other children… the injuries she seems capable of causing are significant}”. The mother told the Social Worker that Sibling 2 would not take her medication and the Social Worker contacted the Community Paediatrician, who made a further referral to the ADHD service. Children’s Services also noted the Community Paediatrician’s advice that if Sibling 2 took her medication it should be sufficient for other interventions to be successful. It was agreed by the Social Work Manager that extra resources would be provided to help with this.

vii. In December 2013, the Social Worker and her manager concluded that if there was no improvement in the next few weeks Sibling 2 would need to be accommodated by the Local Authority. The Targeted Support Team visited for the first time on Christmas Eve and then visited weekly. A further service was commissioned by Children’s Services from a private organisation, CF Social Work. This was to provide a month of daily visits each lasting 4 hours but ended when a complaint was made about a worker and it was noted that there was in any event little improvement.

viii. By January 2014 the Social Worker was visiting weekly and the Targeted Support team were visiting twice weekly. Over the next three months Targeted Support visited the family on over 40 occasions. During these sessions, a

\textsuperscript{5} Home Based Support and Targeted Support are Children’s Services resources available to Social Workers.
variety of work was undertaken and a number of issues of concern were identified:

- Parenting capacity work undertaken with the mother
- Sibling 1 speaking to strangers on Facebook and mother’s lack of concern
- Suicide notes written by Sibling 1 a couple of years previously
- Sibling 2 making penis shapes out of PlayDoh

ix. Over one weekend the Targeted Support Team worker became involved in arguments that were going on in both parents’ houses in front of the children and was abused and spat at. This worker expressed concern to the Social Worker about the safety of the children. It was agreed with the Social Worker that the mother would, for a trial period, spend alternate nights away from home, and other family members would step in to provide the care on those nights. Different agencies recorded different information as to the care arrangements for the children and whether the father was ‘supervised’ in his contact.

x. At the end of January 2014 Sibling 2 and her parents met with the ADHD Community Psychology team for an assessment having been referred by the Community Paediatrician. The Psychologist liaised with the Social Worker, Targeted Support Team and the school and attended CIN meetings. One of the issues identified to the team by school and family was that Sibling 2 had difficulties leaving her mother. This assessment was completed in April 2014 and identified that Sibling 2 had some learning difficulties and would require additional support at school. It was also agreed that an assistant psychologist would undertake individual sessions with Sibling 2 to help her with her anxiety. A referral had also been made by the school to the Educational Psychology Service although at the first meeting Sibling 2 refused to see the Educational Psychologist alone and when seen with her mother Sibling 2 appeared reluctant to be assessed. The mother was described as not overly worried about Sibling 2’s learning and felt that her behavioural problems were at home not in school.

xi. The mother during this period had been referred to the Hospital Outpatient department by the GP but failed to attend on a number of occasions and was subsequently discharged by the team. This identification of health problems by the both mother and father, followed by a failure to attend appointments was a repeating pattern.

xii. In March 2014 the Social Worker had returned to monthly visits and the TST team to weekly visits. The rationale for this change was not recorded. Children’s Services records identified that Sibling 1 was not attending school and not being encouraged to do so. She was also said to be Skyping older boys ‘worldwide’ while she was in the bath and she was self-harming. It was further noted that her mother did not seem to be aware of where 12-year-old Sibling 1 was much of the time. Sibling 1 attended the Mental Health Access and Assessment team where she was seen to have superficial cuts to her wrists but was not diagnosed as having a mental illness.
III. April 2014 – March 2015 Core Assessment completed and first consideration of foster placements.

i. The Core Assessment initiated in November 2013, was completed in April 2014. It recommended that:

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

ii. The Social Work Team Manager noted that the parents were willing for Sibling 1 and Sibling 2 to be accommodated by the Local Authority, but not Sibling 3 and Sibling 4. Their grandmother was said to be willing for the two youngest to live with her if this was felt to be necessary. Legal Advice had been taken and it was agreed that the threshold for removal had been met for all four children. The plan was that “this would only be considered if alternative education or therapeutic provision can be found and intensive support within the home proves not to be successful.” All four children were also referred to the Young Carers service.

iii. In May 2014 Sibling 1, was with an older female friend when she was sexually assaulted by an adult male who was known to them. This was reported to the Police and the man concerned, who was known by Police to be a Schedule 1 offender was later charged and convicted. It was recorded by Children’s Services that Sibling 1 was spending time with a group of friends older than her and said to have a 19-year-old boyfriend. Advice was given to the mother about keeping Sibling 1 safe. Discussions with Sibling 1 in the following weeks suggested that she did not accept she was at risk. There was liaison between the Police and Children’s Services about Sibling 1’s vulnerability and what action would be taken if she was found out after 7.30pm.

iv. A Children’s Services management review in relation to Sibling 1 took place and described the situation as fluctuating. The review records concern as to who Sibling 1 was associating with, the care in the home and the lack of parental attention being given to the younger children. There is no record of any discussion or decisions regarding the previous recommendation of accommodating Sibling 1 and her younger siblings in foster placements. The school contacted Children’s Services worried that there was no progress there no information about the response has been found. The school SENCO contacted the Educational Psychologist requesting a statutory assessment

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6 Schedule 1 Offender: term previously used to describe a person who has been convicted of an offence against a child listed in Schedule One of the Children and Young Persons Act.

7 SENCO: Special Educational Needs co-ordinator.
regarding her educational needs, but this was not agreed on the basis that it was felt to be a means to manage poor school attendance.

v. In June of 2014 a professionals meeting took place chaired by the Children’s Services Team Manager. As well as the Social Worker and her manager 11 professionals from other agencies attended and three others gave apologies. The manager noted that given the numbers involved it must be difficult for the family. The plan for a Boarding School placement for Sibling 1 was confirmed, as well as referrals to the Rose Project\(^8\), a specialist activity holiday and Family Group Conferencing. The Psychological assessment, a CAMHS assessment and a TST assessment were noted as continuing. CAMHS later declined to offer a further service as there had been a previous assessment. A Boarding placement was also to be considered for Sibling 2. Sibling 4 was to move to a School for children with special needs at the start of the autumn term.

vi. At the end of that month, the Child in Need Team Manager reviewed the case and recorded concern about the lack of progress. The Manager considered the current plan was achievable but concluded that a change of Social Worker was required. Agreement had just been granted by the CSC Admission to Care Panel (ATCP)\(^9\) for a Boarding School place to be found for Sibling 1 locally. The evidence available at this point was that all the previous concerns remained and some, for example Sibling 2’s school attendance, were becoming worse. A new Social Worker was allocated the case in mid-July.

vii. During the Summer and Autumn of 2014 there were two further occasions when the Police were called, one a result of abusive behaviour towards Sibling 3 and Sibling 4 by other children, another due to a report that Sibling 2 had been aggressive in the home, although she was found to be calm when the police arrived. Both incidences were reported to Children’s Services. A Child in Need meeting took place but there is limited information about who attended or what was discussed. A mental health representative who attended advised the meeting that Sibling 1 did not have a mental health problem, but that the concerns were about poor parental boundaries and exposure to adult experiences. The mental health team discharged Sibling 1 from their service.

viii. CSC records identify the following during this period:

- all 4 siblings ‘remain at home’
- Fortnightly social worker visits to take place
- Sibling 2 not engaging with the psychologist
- Sibling 1 had been seen by the Bethel clinic and had stated she was thinking of killing herself on her 13\(^{th}\) birthday.
- Sibling 1 absent from home overnight and mother not aware where or who she is with.
- Possibility that Sibling 1 is at risk of Child Sexual Exploitation
- Grandmother had admitted to hitting Sibling 2 on one occasion

\(^8\) Rose Project: a service provided to young people at risk of or experiencing Child Sexual Exploitation

\(^9\) ATCP: Children’s Services internal process for making decisions as to when an application for a child should be brought into the care system
Mother has ‘adult’ conversations with both Sibling 1 and Sibling 2 and is ‘guarded’ about her current relationship
Sibling 3 and Sibling 4 exhibiting fear at home believed to be in relation to their grandmother’s care style and are sent to their rooms when Social Workers visit.
TST witness grandmother causing Sibling 2 to have an angry outburst.
TST have not been able to effect change and cannot continue the intensive level of support long term.

ix. A potential Boarding School placement had been identified for Sibling 1 and subsequently a place in the same school was also found for Sibling 2. Sibling 1 eventually took up this place in November, but Sibling 2 would not attend and remained at her local primary school. The Community Psychologist offered to provide some family therapy. The mother told Children’s Services that she would agree to them being accommodated by the Local Authority under S20, but would not accept the concerns about Sibling 3 and Sibling 4 and or agree to them being accommodated. Sibling 4 was given a place at a school for children with complex needs starting in September. There was repeating evidence of various appointments being cancelled or not attended by the family, as well as social work home visits during which the behaviour of family members was extremely difficult.

x. In early September 2014 the CSC Divisional Manager requested that Sibling 2’s case be withdrawn from discussion regarding a foster placement. This was to allow further case discussion and further support to be provided to the family. In supervision with her manager in September the Social Worker identified a number of agreed actions in particular including:

- Request for Resource Form to be sent to panel for placement.
- Child Sexual Exploitation consultation with the CSE Decision Maker at the MASH.
- Meeting with Child Psychologist regarding possible additional commissioned resources.

xi. The school specifically contacted the Social Worker stating their concerns about the family’s ability to make meaningful changes and stated they would be concerned if the foster placement plan was no longer being pursued. At around this time a Family Group Conferencing co-ordinator10 became involved. There were no signs of improvement and evidence of some things worsening, including Sibling 1’s self-harming. Sibling 2 now told the Social Worker that she wanted to go to a foster placement. The father was said to have disengaged from involvement with services. The Social Worker noted that Legal Advice

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10 Family Group Conferences Family Group Conferences (FGC) are meetings which bring children and families and their wider support networks together to jointly find solutions to the difficulties the family are experiencing. This service was at the team commissioned by Break, a charity working with children.
would be sought, with the expected outcome being that a letter would be sent to the family explaining the process before legal action could be taken.

xii. In late October 2014 a Children’s Services Operational Manager who had reviewed the case with the team manager concluded that the Sibling 1 and Sibling 2’s situation was urgent and required a legal strategy meeting as to whether the threshold for care proceedings would be met. This manager also asked what plans were in place to meet Sibling 3 and Sibling 4’s needs but did not include them in the request for a legal meeting. In particular, there is reference to undertaking wishes and feelings work with the two younger siblings in relation to Older Sibling’s behaviour and not allowing Older Sibling to discipline or parent the children. The information provided does not explain why this was necessary.

xiii. The legal meeting took place the following week and the family were advised to contact a solicitor. The Admissions to Care Panel (ATCP) agreed to a 6 week foster placement for Sibling 2, who continued to show interest in this despite her mother’s negative views about it. During one social work visit she said that her mother told her she did not have to answer any of the Social Worker’s questions if she did not want to, after which weekly visits were put in place outside the home to prepare her for the placement. At the end of November, the ATCP met again and agreed that Sibling 2 should be in a foster care placement while therapeutic work continued. In the following weeks Sibling 2 asked on several occasions about going into foster care again and whether she would go into care ‘if she was good’. At a Review Meeting with the Community Psychiatrist, the mother said that there was an improvement in Sibling 2’s behaviour and that the medication seemed to be working.

xiv. There were continued concerns regarding Sibling 1’s self-harming and worrying relationships with boys, again with no apparent concern shown by her mother. Once again, her GP, asked for a CAMHS assessment, which took place and identified a risk management plan. In December 2014 Sibling 3 told the safeguarding lead at her school that she had ‘one big worry’ but she did not want to talk about it and that sharing it would mean she would get hurt. When asked more she went on to say that it was about family members who had died, including her mother’s boyfriend in Kent. Children’s Services had requested further intensive support from Home Based Support for the family in the form of 6 hours a day for 4 weeks.

xv. In the first week of January 2015 the Police were called when Sibling 1 did not return to boarding school and then ran away from home. When she was found by the Police she said that she did not like school and was worried about her mother’s health and ability to cope. She showed the officer the scars from her self-harming and spoke of idolising rock bands, and particularly where individuals had taken their own lives. The officer was concerned about her mother’s response and made a referral to Children’s Services. The same day a ‘Letter Before Action’ Meeting\textsuperscript{11} (meeting with the authority’s legal advisors)

\textsuperscript{11} ‘Letter Before Action’ meeting: This is the term used at the time when referring to the Public Law Outline Pre-Proceedings meeting with social work staff and Local Authority legal department to consider whether care proceedings should be initiated.
concluded that there should be a further period of testing for both Sibling 1 and Sibling 2 and a review in four weeks. The ATCP would not agree to a foster placement for Sibling 1 without an Interim Care Order in place. Another management discussion took place a couple of weeks later about the possibility of considering a Child Protection Plan, but it was felt this would not change anything for Sibling 1.

xvi. Another ‘Letter Before Action’ meeting took place in early February. There had a few days previously been a further referral from a Police Community Support Officer who knew Sibling 1 from previous contact with the family and who she spoke to about her distress, loneliness and self-harm. At this meeting it was agreed that the Local Authority should initiate Care Proceedings for Sibling 1, in the meantime seeking a foster placement with parental agreement under S20. In relation to Sibling 2 it was decided to test out her progress after Sibling 1 had left the home. Work would continue with Sibling 3 and Sibling 4 who remained assessed as Child in Need. Neither Sibling 1 nor Sibling 2 were attending school at this point, but given the Local Authority’s decision, the School Attendance service decided not to pursue their legal case. A senior management review by Children’s Services noted concern about chronic neglect, the case drifting and the future risks to the two younger children. The Social Worker was required to provide a chronology for each child and a genogram.

xvii. Over the following weeks there continued to be episodes of concern in relation to Sibling 1, including being missing for several days, spending time with an older friendship group of concern and her mental health. Sibling 1 was identified by Police as at risk of child sexual exploitation. A number of actions were taken including the issuing of a Child Abduction Warning notice to one of the adults of concern. The Police Community Support Officer who visited the house to explain that the Warning Notice was in place made a detailed record of the poor conditions in the home and evidence of neglect.

IV March 2015 to October 2015 The children are placed in Foster Care and the first disclose of sexual abuse.

i. In March 2015 Sibling 1 was placed in Foster Care with her mother’s agreement, under S20 of the Children Act. Concerns continued to be recorded about the three younger siblings, including deteriorating home conditions and increasingly distressed behaviour. It was again noted that there was ‘drift’. There were more discussions about a boarding school placement for Sibling 2, but no further decisions were made in relation to her at this time. Sibling 1 began to settle in her placement, although there were problems with her contact with her mother, who was not following the contact agreement, by for example allowing Sibling 1 to access social media.

ii. In April 2015 there was a Family Court hearing at which the following were agreed:

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

iii. At the end of May 2015, the Father was admitted to hospital where he was found to have a condom in his small bowel which required an operation and a two week hospital stay. He could give no explanation as to why or how this had happened. Around the same time the children were found to have scabies.

iv. The independent Educational Psychologist’s report, completed in relation to Sibling 2, identified that she was experiencing significant depression, anxiety, anger and disruptive behaviour and ‘emotionally based school refusal’. It concluded that she had moderate learning difficulties, but her needs could be met in a mainstream school rather than boarding school which Sibling 2 and her mother wanted.

v. An independent Clinical Psychologist’s report which had been ordered by the Family Court was received by Children’s Services in July 2015. This report identified that Sibling 1 had experienced multiple traumas, including sexual assault and stated that she remained exceptionally vulnerable. It further identified significant concerns for all four children, who were said to need ‘above average parenting’ and concluded that the younger children could be expected to experience the same mental health problems as their older sisters in the future.

vi. A Social Work Core Assessment was completed in July 2015 and the contents shared with the family. No decision had been reached as to whether there should be Care Proceedings regarding Sibling 3 and Sibling 4, although further Legal Advice was being sought. The mother’s view was that she would be able to care for the younger children if Sibling 2 was found boarding school and foster placements. On 6 occasions during July the Police were called after Sibling 2 was said to have assaulted family members and caused damage in the home. On one of these occasions it is recorded by the Police that Sibling 2 went to stay with her father but Children’s Services recorded that she went to her older sisters to calm down. On another occasion it was recorded by the Police that she was taken to her father’s address as he was able to control her. The day after Sibling 2 was taken to her father the Police were again called after she was said to have assaulted him.

vii. Children’s Services records at this point identify that Sibling 1 and Sibling 2 had been significantly harmed by their parenting. The plan for Sibling 1 was to remain at her boarding placement and foster placement with therapeutic intervention. Sibling 2 was noted as requiring a stable foster placement and it was recorded that the Authority would seek a Care Order on her behalf. A Placement matching form for a foster care placement was completed. The form submitted had previously been completed and submitted in November 2014, and new information, including that within the Independent Psychological Assessment was not included. It was noted that there was a risk that the parents would undermine a placement. The plan for Sibling 3 and Sibling 4 was that mother would receive intensive support for 3 months, but that the contingency plan was to apply for care orders for the two younger siblings.

viii. On 12th August 2015 an Admission to Care Panel confirmed there would be a Foster placement for Sibling 2; Sibling 1 would be referred to the Children’s
Case Advisory Service and Sibling 3 and Sibling 4 would be returned to Panel in 6 weeks for further discussion. The Children’s Case Advisory Service would commission intensive daily support within the family home alongside a parenting assessment over a 12-week period.

ix. At the beginning of September 2015, a foster placement was identified for Sibling 2 and she finally moved towards the end of the month. From the outset there was considerable concern about her behaviour. Within a very short space of time Sibling 2 described her younger sister as having initiated sexual activity with her and making her perform sexual activities. A Strategy Meeting took place and it was agreed that a S47 Core Assessment should be undertaken.

x. Just a couple of days later, on a Sunday in early October 2015, Sibling 2 disclosed to her foster carers that she had been sexually abused by her father. Her foster carer contacted the Children’s Services Emergency Duty team that evening. The Emergency Duty team contacted the mother who confirmed that the other children were at home with her. Given that the father did not live in the home it was concluded that there was no necessity to take urgent safeguarding action that night, but that a full response would be required from the allocated Social Worker the following morning.

xi. The following morning the Social Worker told the mother that an allegation had been made by Sibling 2, though no further details were given. The mother was told not to allow any contact between the father and the children until she was given further information. A strategy meeting was arranged between the Police and Children’s Services, but no record of that meeting has been identified. Both parents were arrested, and Sibling 3 and Sibling 4 were removed under police protection powers and placed with separate foster carers.

Section 3:  Post disclosure October 2015 onwards

i. On the day that Sibling 2 made disclosures of having been sexually abused by her father, there was some disagreement between Children’s Social Care and the Police as to the approach that should be taken with the family. The Police position was that the children should be subject to immediate police protection, whereas initially the CSC manager considered that the children were safe to remain with their mother and wanted planned interviews and any removal to take place at school the following day.

ii. Foster placements for Siblings 3 and 4 were already being considered within family court proceedings, these were accelerated during the day and the children were taken into police protection at 7.30 that evening.

iii. Over the following weeks and months all 4 siblings made a number of disclosures of sexual abuse. These ultimately resulted in the prosecution and convictions outlined at the beginning of this report.
3 FAMILY CONTRIBUTIONS TO THE REVIEW

This section of the report documents the views and understanding of the family members about the services they received as they explained them. Those views and their perceptions of what was either helpful or unhelpful are presented in this section in their own right without comment or analysis. Where family members have referred to practice that would not be considered to meet acceptable standards, these will be considered in the analysis section.

3.1 Mother

3.1.1. The children’s mother prepared a written document for the meeting with the Independent Reviewer and Board Manager, outlining her reflections on the family and in relation to the involvement of services. This then formed the basis of a fuller discussion and the contents are summarised as follows.

3.1.2. The mother described her relationship with the father as initially fine but said that he began to become domineering in a subtle manipulative way over time. This was expressed by taking over domestic tasks when she began to have health problems which eventually wore her down mentally and emotionally. She described this behaviour as ‘suppression’. She also spoke about the difficulty of living with his mood swings and depression and said, ‘in the end he wore me down to such an extent I could hardly function’. The mother spoke about the help her own mother would give her.

3.1.3. The mother described having a very close bond with Sibling 2. She described Sibling 2 as having separation problems in relation to her father when she was younger, but that this shifted back to the mother when the couple separated. She described Sibling 2 as becoming distressed and physically violent at any separation from herself. Sibling 2 would constantly seek her attention and would cling to her mother when she was taken to school and refuse to go in. After the parents separated she said that Sibling 2 was happy to go to spend time with her father initially although she would sometimes say she did not want to go to see him. Sibling 2 would worry about her father being lonely and would often spend time with him in the holidays.

3.1.4. She spoke of Sibling 1 as a very bright child who needed a good education but had attendance issues and at her age she was not able to run after her. She described Sibling 1’s mental health as being fine until the point that she (mother) had to go into hospital with a serious health problem that could have killed her. It was Sibling 1 that had found her and rung for help and she felt that afterwards Sibling 1 was scared that her mother might have died and she became very anxious. She confirmed that Children’s Services tried to help Sibling 1 and that the GP referred her to CAMHS, but that they said she didn’t need any mental health help. Mother described Sibling 3 as having no issues and that Sibling 4 had issues around global development delay and hypermobility and that all her needs were met.
3.1.5. The mother was adamant that she had never suspected sexual abuse and that the children had never said anything to her about it. This was something she had thought a lot about and she wondered whether she missed anything? She recognised that she sometimes switched off with Sibling 2 who was always on at her. She said ‘If I had had any inkling, I would have ripped his head off’. She felt that someone should have told her that there had been allegations of sexual abuse previously by a member of the father’s birth family years ago. The father had later asked for his records from Children’s Services in the county where he had lived at the time, but a lot of the information was redacted, so she had no way of knowing what it said. She thought that the Children’s Services in that County should have told someone in Norfolk Children’s Services.

3.1.6. The mother said she had some concerns about the services the family received. She had told the Social Worker (in 2013) that she thought the father’s contact with the children should be supervised because of his mood swings. A worker was identified who then supervised contact, but this ended because there was a problem with how the worker restrained Sibling 1 and they were never given another worker. The mother then supervised contact herself and later agreed that the father would have the children on alternate weeks and that he would have Sibling 2 on his own and Sibling 3 and Sibling 4 would go together. Her mother supervised until the children were in bed. Later she asked again for the father’s contact to be supervised, but the Social Worker told her it was her responsibility to ensure contact was maintained.

3.1.7. The mother valued the support provided by the Targeted Support Team and particularly appreciated one of the professionals from that team who she felt understood her, she felt she spoke to her like an equal and that she could relate to her. She felt that some of the Social Workers did not really understand how difficult it was with Sibling 2 and did not seem to believe her about how aggressive Sibling 2 could be until they saw it for themselves. She felt there was constant pressure and scrutiny on her and not on the father and that she was expected to protect the other children from Sibling 2’s attacks, even though you did not know when it was going to happen.

3.1.8. The mother was critical of Children’s Services for the way they managed finding a placement for Sibling 2. She said that it had been her idea for Sibling 2 and Sibling 1 to go into foster placements as she felt this would benefit them and the family as a whole. However, she thought it was badly planned particularly as the Social Worker told Sibling 2 about a placement which she, as her mother, could not agree to as it did not seem suitable and then Sibling 2 had to be told it wasn’t happening. Sibling 2 then got it into her head that her mother did not want her, despite all her reassurances. “I spent almost 9 months with her telling me she wished that I had died when I was seriously ill, regularly violently attacking me she wished that I had died when I was seriously ill, regularly violently attacking me and other people for no reason.”

3.1.9. She said that it was not all about Sibling 2, but it was Sibling 2 where the problems were. She felt that she needed more help earlier with Sibling 2 who started displaying aggressive behaviour when she was about two and a half. She described in detail how difficult it was getting Sibling 2 into school.
Looking back, she thought this might be because Sibling 2 felt safer at home. Having the diagnosis of ADHD and mixed neuro development helped but she said that she was not given much information about the diagnosis or what support would go with it, which was important as different traits across the spectrum need different support.

3.2 Maternal Grandmother

3.2.1. The children’s maternal grandmother identified many of the same experiences as her daughter, including Sibling 2’s violence and the lack of supervision of the father’s time with the children. She felt particularly that Children’s Services seemed more concerned with monitoring her daughter than the children’s father. Her view was that the father was alright when he took his medications and could be a loving affectionate dad, but she was always vigilant when he was around because of his mood swings. She also felt that ‘the father had hoodwinked lots of people’. She confirmed that they had been given lots of support, ‘all for the right reasons’ and that the Family Unit had been very helpful. She had not always agreed with the approach some workers took, for example one of the Family Unit officers said they would give Sibling 1 an expensive ticket to a concert if her school attendance improved and questioned why they would reward her for something she should be doing. She described herself as stronger and she believed that you shouldn’t let children rule you.

3.2.2. Maternal grandmother was of the view that it was the sexual abuse of Sibling 2 by her father that had made her violent, which they did not know at the time. She spoke about Sibling 2 not being willing to take her medication and how they had tried for ages to get an educational statement for her. Professionals thought that her behaviour was down to bad parenting, but the doctor changed this attitude with the diagnosis. Grandmother questioned how the mother was supposed to know about the sexual abuse if the children did not tell her.

3.2.3. Maternal grandmother described having a lot of involvement with the children’s care, she would get there early to get the children to school, would do a lot of the housekeeping and decoration and if the mother’s legs were playing up she would do the shopping. The mother could not do heavy housework because of her health problems. Grandmother thought the CAF and Child in Need meetings worked well as they came up with plans, such as taking the younger children off their mother so she could have more time with Sibling 2. She also felt that the school had been very good. Grandmother and mother talked about all the decisions involving the children and were always in agreement.

3.2.4. Grandmother also described Sibling 1 as very bright and believes she was bored at school although with hindsight she wondered if her absence from school was a cry for help. She felt that the house fire which had happened when Older Sibling was about 9 years old had traumatised him and said that that was when he started having problems. She said he was placed in a special unit for a time. However, Grandmother was never worried about Older
Sibling as he was never left alone with the children other than when he and the father were looking after them because their mother ‘was on respite’.

3.2.5. Grandmother was also critical of Children’s Services for the delay in finding Sibling 2 a foster placement and then leaving her in limbo for 9 months before another place was found.

3.3 Older Sibling

3.3.1. The children’s Older Sibling met with the Independent Reviewer and Safeguarding Children Board Manager accompanied by his Probation Officer.

3.3.2. Older Sibling began by saying that he felt that the various agencies could have done more to help his family, in particular that they should have recognised the problems with the father and the younger children earlier. He questioned why the information about allegations against the father when he was younger was not brought up. He spoke about the numbers of different people coming into the family ‘there were people coming in and out every day…..the family was passed from this group to that’.

3.3.3. He said that when the Social Workers first got involved with his family they were ok and helpful. However, his memory of the Social Worker who was involved in 2015 was not positive. He did not like her manner and said she would behave in a way that led Sibling 2 to ‘kick off’, but then blamed this on their mum. He felt that she had influenced Sibling 2 in making some of the allegations and that all she wanted was to take his younger sisters away. He also referred to an occasion when he believed another worker was present when the father had done something to Sibling 2 and yet this worker had not spotted it.

3.3.4. Older Sibling was very positive about one of the workers from the Family Support Team and said that if anyone could have helped it would have been her. He said that she was able to calm Sibling 2 down and helped his mother with her confidence. ‘she seemed like she actually cared and wanted to help’. He also remembered a PCSO who had been friendly and tried to help, chatting to him about his problems. Older Sibling’s experience of school was mixed in that he felt quite happy in school until year 8 (when he would have been 13 years old). At this time, he said he had become very scared for his mother because of the fire his own father had set in the house when he was younger and he became scared to leave her so stopped going to school. He did go back to school later and would attend the Excellence Centre which involved going in on different days and times and this worked for him. But he felt it had been very unfair that he had not been allowed to take his GCSEs, which he said he was told was because he had had a fight when he was in Year 9.

3.3.5. Older Sibling particularly thought that the services could have helped more with Sibling 2, who described as being confused ‘because of her complaints’. He believed that his younger sisters felt terrible pain at ‘being ripped from their
family and each other’. He spoke positively about his mother and said that she loved him and all the children, that she did her best but couldn’t cope.

3.3.6. Older Sibling described getting ‘a little bit of help with his mental health issues’ from the Family Support Unit workers, but that he only had two appointments. He was not exactly sure who everyone was, but he talked about meeting with a ‘younger lad’ who he had connected with, but then an appointment being cancelled and not seeing him again. Another worker had not been helpful and he said that offers of help to get him into employment had been ‘empty promises’. What he felt he had needed would have been to be given help ‘getting my mindset right, sorting my mental health out, help becoming a man’.

3.3.7. He also explained that he had had counselling provide by CAMHS from the age of 10 up to the age of 17. He did not think this counselling was helpful because it was always about reliving the trauma of the house fire, he described having hypnotherapy, but he did not want to relive it, he wanted help to walk away from it. He described suffering from flashbacks and being very stressed when he came out of the hypnotherapy, but that the worker had done nothing to help him calm down afterwards. At the time he had not felt able to say that he didn’t think it was helping. Older Sibling felt that although they knew about the trauma he had experienced they didn’t really understand. He said that he later self referred to the mental health Wellbeing service, but was never given an appointment.

3.3.8. Overall Older Sibling felt that it would have been better if professionals had asked him more about what he wanted rather than deciding for themselves what would work for him. He believed this meant that he was often ‘set up to fail’. “People could have listened more….they worked around their ideas to a pre-set plan and my thoughts weren’t taken into account”. He felt that what families need is “someone to trust, someone to listen and help instead of having the mindset of ‘do it my way’”.

3.4 Sibling 1

3.4.1. Sibling 1 provided a powerful and rather dismal picture of her experience of social work during the time period of this report. She was not impressed that Social Workers behaved as if they knew her whole family even though they only saw them once every 6 weeks. Her overwhelming response was that she was irritated by being told what to do by people who barely knew her. In her words, “if I’m not going to do what my mum tells me, why do you think I’m going to listen to you when you have only met me for 5 minutes”. From Sibling 1’s point of view, these were complete strangers who did not understand or know her but still thought they could tell her what to do. She was particularly infuriated with one Social Worker who started telling her what to do the very first time she met her and would say, in what sounded like quite a bossy manner, that ‘this was the bottom line’.

3.4.2. Sibling 1 did feel that a couple of workers were better, although because of how she was feeling at the time, she still would not have been willing to talk to
them. What made a difference was when people spoke to her more like an equal and had a conversation with her that didn’t feel she was being talked down to. She said that she knew she was a ‘bit of a bitch’ and wasn’t open to speaking to professionals. She had felt that everyone was ‘constantly on my case’ and that just had the effect of making her more rebellious than she already was. She knew in her head at the time that she was probably making the wrong decisions, but that was just what she was doing.

3.4.3. Although she was offered other services to go to for support she simply was not in the frame of mind for them. The offer of Young Carers she felt was particularly pointless. She did not see herself as a Carer, she was simply doing things like making her mum some toast or a cup of tea, things that anyone would do for their mum. Sibling 1 was also especially critical of her experience of CAMHS. She described going for a first meeting and actually beginning to talk quite openly about herself. She had been having suicidal thoughts and was still anxious about her mum. But she said that their report labelled her a ‘manipulative attention-seeker’ and she shut off completely. She said that experience stopped her wanting any counselling. Although she has more recently had some counselling she is clearly still a little distrustful of the process. She was also referred to the Rose Project because of the CSE but only went once as she couldn’t see the point.

3.4.4. Sibling 1 described being out of the house a lot of the time, mostly spending time in a park in the city where drug users were. She said that she only smoked weed but now realises that she was at quite a lot of risk. There were several things that were happening which meant she was in her words ‘rebelling’. Being the one who had to call for help when her mother had ended up in hospital evidently had a powerful effect on Sibling 1. As well as what was happening with the father, she said she was also being bullied at school. And of course, she was a teenager.

3.4.5. Sibling 1 was very critical of the way the Social Worker, and others, had viewed the father. When her mum was having respite, the Social Worker thought he was the better parent and wanted him to have more contact with the kids. He would come over to the house and look after them. He had fooled professionals. Whilst Sibling 1 knows that the Social Worker didn’t know what else was happening, and she didn’t mean to, but she put her and her sisters at more risk from the father. “You could see that with his mental health issues he wasn’t capable…just that, without anything else that was going on.”

3.4.6. The way that she was told about going into care had made her very cross. She said she was not asked what she thought or ever told in advance that it was a possibility. She should have been given a chance to say what she thought. When she first went to boarding school, she was there all week, just coming home at weekends. She had been out of school for most of the last 3 years and it was quite a change, quite fun. But after being at home for the Christmas break she didn’t want to go back. The Social Worker threatened her with going into Care then and said, ‘the bottom line is boarding school or no school …so of course I chose no school…’. After that she had spoken to her mum and then with her mum and the Social Worker and they said they
were looking for foster placements. Sibling 1 said she ‘went mental’, she had never been told Care was a clear option. She was told it was because she was a high risk of CSE. At the same meeting she said that the Social Worker told her mum to look into her children’s eyes and tell them she had failed them. Sibling 1 thought that was a terrible thing to say.

3.4.7. Sibling 1 did not think that she would have been able to talk to anyone about what was happening with her father at the time. There were opportunities to say something, but he had threatened her. She was scared to tell anyone. But with the right person and right approach she might have talked about other things, like her mother nearly dying, and perhaps that might have led on to something else. The Social Workers at the time never saw her on her own, although one of them did try. Her sisters wouldn’t see them on their own either.

3.4.8. When she did go into a foster placement it initially worked well and she really liked the family. She started going to school again. But the placement broke down after Sibling 2 told people what had happened, and her mother was arrested. That was in her exam week and she was told at school and then was told she couldn’t see her mum. She wanted to see her family and friends and be distracted so she stayed at school for three weeks. The Social Worker thought this meant she should have a different foster placement so then she changed. Eventually Sibling 1 decided she also had to say something or the father would get a shorter sentence. The first person she told was her foster sister.

3.4.9. Sibling 1 also spoke about her life since her sister made the disclosure. In particular she found it really difficult that she was not allowed to see her mum and her sisters. ‘I didn’t have anyone at the time I needed my mum most’. She said that no-one had ever really explained why this was. She thought that once everything was over she would be told more but that hadn’t happened. She can see her mum now and her mum has told her, but she has never been told by anyone why she couldn’t see anyone at that time. It was very lonely. Sibling 1 also questioned why she was not allowed therapy before the trials. Again, she said that no-one had ever talked to her about this.

3.4.10. It had also been difficult for Sibling 1 to understand why she could not see Sibling 2. She said that she loved her little sister to pieces, but when they were younger she had been angry with her because of her behaviour with their mum. She now understood more that this was about Sibling 2’s special needs. She also wanted to know more about the father’s convictions, she knew there were other people who had been abused. She could guess who this might be, but no-one had told her. Sibling 1 accepted that there might be some difficult things to hear but said “I am 16. I can handle it. Everything’s sorted now, but I still have questions….it would help me move on.”

3.4.11. What Sibling 1 really wanted was someone who would just be there for her. Someone who would listen, not nag and tell her what she should do all the time. Just listen and be there for her.
3.4.12. As a result of what Sibling 1 said about not knowing some important information about her family, the Independent Reviewer asked Children's Services to ensure that all relevant information was shared with her. An arrangement was therefore made for Sibling 1's Social Worker to specifically prepare Sibling 1 for the fact that there would be information and views in the Serious Case Review some of which might contradict her understanding of what had happened in the family.

3.5 Sibling 2

3.5.1. The Independent Reviewer and Board Manager met with Sibling 2 in the residential unit where she is currently living, supported by the House Manager. Sibling 2 had been nervous about the meeting but spoke quite openly given the circumstances. The House Manager confirmed that what Sibling 2 said reflected their understanding of her experience. Sibling 2 also said that the Independent Reviewer could speak to her Social Worker about how she felt. Sibling 2 was very positive about her current Social Worker. “she helps a lot, she is good at talking”.

3.5.2. Sibling 2 remembered various professionals, including teachers at school that she had liked and some that she did not. She said that she hated school because she was bullied and beaten up. Sibling 1 did not go to school and Sibling 2 thought that was clever. Sibling 1 told her not to go to school, so she did not go. Sibling 2 is now attending school every day and making very good progress.

3.5.3. Sibling 2 could not have been clearer about what the Social Workers could have done to help her “they could have got me out of the house sooner. They could have got me out when I was four”. Of those she remembered there was one Social Worker she really did not like and said that she talked a lot of junk and that the Social Workers tried to get her into school when she didn’t want to go. When she was not in school she would be at home watching television.

3.5.4. We talked about her understanding of the diagnoses she had been given. “they kept putting me on tablets. It was stupid. None of it made sense”. Sibling 2 is very pleased that she had been taken off most of the medication she previously had. She now only has medication to help her sleep and she is going to see the Community Psychiatrist soon to see if she can also stop this medication. She told us that her family always said she had special needs and that her father used to push tablets down her throat. She questioned whether this had been right. The Home Manager spoke about how much progress Sibling 2 had made, she had lost a lot of weight, she was going to school every day, had friends and was doing activities. Sibling 2 was obviously proud of what she had achieved and told us in particular about horse riding which she does regularly.

3.5.5. Sibling 2 talked a little about who she had told about what was happening to her. She said that she told her best friend and told her why she was always
running away and ‘kicking off’. She thought about talking to her friend’s mum, but then she didn’t say anything, because ‘she had her own kids to worry about’. She felt that no-one was listening to her. She talked to one of her older sisters, but she lived a bit far away and she couldn’t speak to her about the abuse. Sibling 2 was very clear that she had told her Mother a few times and her Mother’s response had been “so shall we call the police?”. Her older sister said not to do this as they would end up in Care, which is what happened. Sibling 2 did not like going to CAMHS. “I didn’t like talking…. I was worried they might guess”.

3.5.6. Sibling 2 did not really understand why she was being taken into Care and taken away from her sisters. But when she got to her first foster placement, the foster carer listened to her and that is when she told. Sibling 2 said “dad told me not to tell anyone what happened. But I don’t keep secrets about that horrid stuff. They only secrets I keep are birthdays and Christmas”. Sibling 2 told us that she is doing life story work and the abuse is just Chapter 1. We asked Sibling 2 what would help other children like her in the future and she replied:

“it would help if you make sure they’re safe. Put them in a safe place. If I wasn’t in care I probably wouldn’t have survived”

3.5.7. Meeting Sibling 2 allowed us to see a young person who has made incredible progress since she first disclosed what happened to her. She feels safe, she has ‘nice adults’ around her, she is making progress at school, she enjoys seeing her younger sisters, and she has reached a point where both she and the professionals around her are questioning whether any of the diagnoses that she previously had are in fact accurate. The Sibling 2 we met and who is now known to her Social Worker and other professionals, is a funny, quirky and endearing individual very different from the picture that might otherwise have emerged during this Review. We asked her what message she would want to give to professionals who had worked with her before and she replied: “I’m fine, thanks.”

4. APPRAISAL OF PRACTICE AND ANALYSIS

4.1 Introduction

4.1.1. This Section will appraise the key aspects of multi-agency practice that have been identified by this Review. It will consider what multi-agency learning there may be for future practice in respect of the Terms of Reference outlined by the Safeguarding Board and any other learning that might have emerged. This analysis will also take into consideration the NSCB’s Thematic Learning Framework. The analysis will be structured under two overarching headings:

- Understanding what was happening in the family
- The responses to the children’s needs.
4.1.2. The analysis will consider the key features of the practice of those agencies involved, identify where practice standards may not have been met and seek to understand why this may have been the case. It will use examples to illustrate the most significant aspects of practice. Through this approach it will reach conclusions about the significant learning which has relevance to current and future working practice and processes.

4.1.3. Where individual agencies, or the multi-agency partnerships, have already established appropriate learning, and taken action within their agency, this will not result in further recommendations within this Review. Similarly, where practice has already been addressed, including as a result of previous Serious Case Reviews further recommendations will not be made.

4.2 Understanding what was happening in the family

4.2.1. At the core of these children’s experience was the difficulty professionals and agencies experienced in making sense of what was actually taking place within this family. Whilst this Review cannot assume to fully understand all the complexities of the children’s experience it is clear now that both neglect and sexual abuse were present. There is no doubt that different professionals and agencies identified neglect of the children as a cause of concern from as early as 2006, when Health Visitor assessments recorded concerns about the home environment, parental capacity to respond to the children’s needs, parental mental and physical health problems and the impact of all these on the children’s development. Whilst this was recognised by many of the agencies, the chronic nature of that neglect and its implications for the children were too slowly identified and responded to.

4.2.2. What is now also clear but was less so for much of the time under consideration, is the limited capacity of the parents to meet the children’s needs over time. While often presenting to agencies as cooperative, in reality the children’s carers repeatedly failed to make the positive changes that the children needed. This was without doubt recognised by some of the professionals involved, for example the Family Support team explicitly ended their involvement in an attempt to highlight the lack of progress. It was also the case that by 2014 problems with parental ability or willingness to make changes was also being recorded by Social Work managers and the outcome of these concerns will be considered further in this report.

4.2.3. However, it was not until Sibling 2 was removed from the home and made a direct disclosure to her foster carer that the reality of the sexual abuse which had been taking place within the family was finally understood. Again, with hindsight it is possible to identify that there was both direct evidence and symptomatic evidence that some of the children might be experiencing sexual abuse. There is no doubt there were concerns at the time about the children and, for some professionals, a sense that there was something else behind the children’s behaviour. However, for reasons which will be explored later in this analysis, this did not lead to an understanding of what was taking place.
4.2.4. The issue of neglect and the quality of the multi-agency response in Norfolk has been explicitly recognised as an area for improvement for the partnership and has been a priority area for the Safeguarding Children Board since 2014. A number of Serious Case Reviews and other multi-agency reviews have previously identified neglect as an area of concern, as did the 2015 Ofsted report. A Revised Neglect Strategy was adopted in June 2017. This both identifies neglect as a top priority for the board and recognises that further work is needed to ensure effective identification and response. Specific steps have been taken by the partnership including the introduction of the Graded Care Profile\textsuperscript{12} and the use of Signs of Safety\textsuperscript{13} which are subject to ongoing monitoring and outcome evaluation. The response to neglect in relation to this family reflects the wider concerns identified for the partnership at that time. Given the continuing level of recognition and response to neglect, this will therefore not be considered in further detail except if there is new learning as a result.

4.2.5. The history of Family U as seen and experienced by all of the agencies involved with them, was of multiple problems and needs. They were a family living in one of the most economically deprived parts of the county\textsuperscript{14}, where many services were under significant pressures to meet the needs of families they worked with. This was a family, with a large number of siblings, the older of whom were living away and about whom there is limited information. Older Sibling seemed to be in the home more frequently, sometimes with a girlfriend. It was not always clear if and when he was actually living in the home, but it was known to some that he at times took on a parental role with the younger children. There was little recorded as to any relationship between Older Sibling and Sibling 1 and their own father. Whilst there was some information about family history, there is little evidence that this was well understood by any one agency or professional working with the 4 younger children.

4.2.6. Not only were there multiple problems apparent within the family, it is also clear that professionals working them could also be faced with situations of fairly high emotion. School staff referred to there being constant dramas and another professional referred at one point to a ‘hysterical atmosphere’ in the home during a visit. Professionals were not infrequently witness to or attempting to help deal with a variety of difficult situations: attempts to get the children out of the house and to school; Sibling 2 in highly visible distress including becoming violent; Sibling 1 walking out or running away. Professionals did not experience threatening behaviour themselves from the mother or grandmother, although there were some recorded incidents with the father. Overall this was a family where there was a significant amount of noise which it is evident had an impact on how professionals were able to respond.

\textsuperscript{12} The Graded Care Profile is an established, evidence based tool for assessing neglect.
\textsuperscript{13} Signs of Safety: An evidence based system for risk assessment and intervention in child protection
\textsuperscript{14} The area in which the family lived was ide identified in the latest Indicator of multiple deprivation as in the bottom 10% in the country. https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015.
4.3 Medical diagnoses and managing behaviour

4.3.1. What is particularly striking is the way in which the children were presented in terms of medical diagnoses. Children’s Services identified that when a new worker went into the house they would be told each child’s name and medical diagnosis. Other professionals described the mother as having her own medical and behavioural file on each of the children although the contents were not shown to professionals. Older Sibling had been identified as having a range of defined conditions, including ADHD and depression. Sibling 4 was diagnosed as having a learning disability and developmental delay and at one point the Mother is said to have pushed to obtain a diagnosis for Sibling 1 as having a bipolar disorder. Information available to the Review since the children’s removal into care raises questions about the various medical and developmental labels given to differing degrees to all the siblings. Rather it would appear, that all the children were showing symptoms of complex emotional damage, trauma and significant attachment difficulties. This was also powerfully reflected in the psychological report prepared for court proceedings in 2015.

4.3.2. It was however Sibling 2 who was most powerfully presented almost entirely in terms of her diagnoses. The mother has told this Review that Sibling 2’s symptoms began when she was only 2 years old. The first reference of any concern was regarding contact with the Speech and Language Team when she was 3 years old and also that she had an Individualised Educational Programme, an approach designed for children with learning needs. At 4 years old she was referred by her GP to CAMHs for behavioural difficulties, including aggressive behaviour and by 5 years old she had been referred to the Community Paediatrician for temper tantrums, developmental delay and eating problems. The Community Paediatrician, who was concerned about Sibling 2’s presentation, referred her to the Health Visitor for a follow up.

4.3.3. From the outset, the Community Paediatrician felt that Sibling 2 was likely to be in need of psychological help rather than the particular medical perspective of a Paediatrician. Despite her attempts to link Sibling 2 with Health Visiting and Psychological or other support, the family continued to bring her back for a Paediatric assessment. The Community Paediatrician ultimately did make a diagnosis of both ADHD and mixed neuro developmental disorder. She did still consider that Sibling 2 may well have had ADHD, but also always felt that there was something else that needed unpicking. She was under some pressure from the mother to provide a diagnosis and her experience was that if Sibling 2’s behaviour was better managed she would be more likely to be able to remain in school which would be in her interests.

4.3.4. The Community Paediatrician described the pressures on doctors to provide diagnoses of ADHD and was frustrated at the appeal that medication holds for many parents. The Paediatrician’s view was that the medical model and system, of which she clearly recognised she was a part, should be changed to focus on a more multi-agency approach with less focus on diagnosis and medication and more on what the cause of the presenting behaviour might be. A Community Paediatrician at that time would see a child on average for 20
minutes every 6 months and would have a case list of 600-700 children. It is therefore evident that in this context, making holistic assessments for children presenting with complex problems in the absence of a full assessment of the family functioning, would be extremely difficult.

4.3.5. The mother, in her contributions to the Review, spoke about how the diagnosis had helped as it had led to “more support and discussions about strategies for managing her behaviour”. What is not explained is how it helped Sibling 2 and indeed, given what is described throughout as Sibling 2’s increasing behavioural problems, it is evident that the diagnosis in itself did not lead to any significant improvements for Sibling 2.

4.3.6. The diagnoses that Sibling 2 had in 2009 however had a powerful impact on other professionals. Over time her diagnoses were routinely referred to by the family as the explanation for all her difficult behaviour and this does not appear to have been challenged by professionals. One of the GPs reflected that once a Paediatrician has made such a diagnosis, they would not consider challenging it. Similarly, school health assessments were focussed on what they understood to be the children’s existing medical conditions rather than taking a more holistic view of their health. The Police were called out to disturbances involving Sibling 2 on 9 occasions in just over a year (2013) but they too accepted the view that Sibling 2 was aggressive as a result of her ADHD. Although the local PCSO who attended the house on a number of occasions made several referrals, neither he nor those in the police dealing with these notifications considered questioning what was happening in the home or sought a response from Children’s Services. In effect Sibling 2’s diagnoses were viewed as even more defining by other professionals than it was by the diagnosing doctor.

4.3.7. Some professionals did consciously try to keep in mind Sibling 2’s symptoms and behaviour rather than just seeing the label of ADHD. The safeguarding lead at the school who had been told that Sibling 2 had various problems including Tourette’s, Autism and ADHD had doubts that there was evidence of any of these. However, the continual reinforcement of these labels obviously impacted on the way the professionals understood Sibling 2’s behaviour and had the effect of distracting from any other explanations. This was not only in relation to Sibling 2 herself, but also to other problems in the family for which she appeared to serve as a scapegoat. There is for example evidence of the Mother distracting family support workers from the other children’s problems by talking about Sibling 2 or by blaming Sibling 2’s behaviour. However, what is evident from the school is that the children were able to make progress when working with skilled professionals. Although this was recognised it did not lead to a fundamental rethinking of what this might say about the causes of the Sibling 2’s behaviour.

4.3.8. It was not only the professionals who were significantly influenced by Sibling 2’s diagnosis. Sibling 2 herself had clearly understood that she was seen to have something wrong with her, asking one professional (CAF): ‘will they be able to make me better?’. 
4.3.9. It must be acknowledged that undoubtedly Sibling 2’s behaviour did become very difficult and that she was witnessed being violent to her family causing bruising and other injuries. She was very rarely violent towards professionals and only then when they were attempting to help the mother or grandmother manage her behaviour. School staff spent a considerable amount of time attempting to coax her into class but on those occasions they succeeded she would settle quite quickly and was described as being fully accepted by the other children.

4.3.10. Whatever the underlying cause of Sibling 2 and her siblings' behaviour, there is no doubt that the adults' powerfully presented views of the children acted like a smokescreen, distracting professionals from other possible explanations. A very similar concern had also been identified in a previous Serious Case Review15, and a recommendation made about the impact of labelling a child with ADHD and the capacity of that label to distract from the quality of parental care.

4.3.11. In June 2017, Norfolk Community Health and Care NHS Trust put in place a new pathway for ADHD and Autism Spectrum disorders. This arose from the recognition that many of the referrals did not require assessment by a Paediatrician and that there needed to be a significant rethink about this approach in order to ensure a quality service to children and families. As a result, a new single Neurodevelopmental Service was created to provide a joint service for children in relation to ADHD and Autism Spectrum Disorders (ASD). This was developed in conjunction with other partners including GPs and schools and has included a revised approach to referral criteria. Children are assessed by a team of specialist nurses, therapists and psychologists and will be seen by a Paediatrician if assessed as necessary by this team. Further work is being developed in relation to a range of interventions subsequent to assessment.

4.4. The adults in the family: The Mother

4.4.1. The children’s mother was the central adult figure in the family and was seen frequently by a range of professionals. However, there appeared to be limited knowledge as to her own family background and what life experiences might have influenced her approach as a parent. Whilst there was some information about significant events in her background, there is no recorded evidence of any systematic attempt to understand her history. In the absence of this sort of information agencies were working without knowing fundamental aspects of what she was bringing to her parenting of the children.

4.4.2. Professionals were very aware of the mother’s own health problems, which were often cited as reasons why she could not undertake particular aspects of child care. The mother experienced some serious medical complaints, including one occasion when she was admitted, as an emergency, to hospital for 10 days. This particular event remained a defining feature of the family’s story. It was viewed and described by the mother and grandmother as a

15 SCR Family L October 2014: Sally Trench and Sian Griffiths
significant explanation both for aspects of the mother’s parenting and for some of the children’s behaviour. As was the case with the children’s diagnoses, this was largely accepted by many of the professionals meaning that other possible explanations were not always considered.

4.4.3. Both Sibling 1 and Sibling 2’s school refusal was linked by the family to separation anxiety due to worries about their mother’s health. Sibling 1 told the Review that she now felt that one of her reasons for being absent so much from the house was linked with her anxiety about her mother dying. Similarly, Sibling 2’s school attendance was considered by the family to be an expression of her need to be with her mother. The underlying reasons for the problems with school attendance, which took up a great deal of professional time and energy, necessitated much greater challenge and exploration, but this did not happen.

4.4.4. It was 11-year-old Sibling 1 who called her grandmother for help when the mother had the very serious health episode that led to her being hospitalised. This would no doubt have had a significant impact on Sibling 1. In a calm, reassuring environment with good attachments between children and their carers, it should have been possible to contain and reduce any subsequent distress or separation anxiety. However, reassuring parenting or praise of children was largely absent from the parenting that the professionals observed. There is for example considerable evidence that all the children were exposed to inappropriate levels of adult information, some of which will have raised anxieties. This included frequent conversations about the mother’s ill health and as the mother described to the Review “they had never seen blood clots like it and I was lucky to survive. This scared Sibling 1 as she realised her mum might have died and she became very anxious”.

4.4.5. Whilst this Review does not doubt that the mother’s health was significant in family life, what is of concern is that this again seemed too easily to become an explanation of the family difficulties. That, for example, Sibling 2 could actually settle well in class once she was away from her mother might have suggested that her relationship with her family was more complicated than was being presented. Separation anxiety disorder is a recognised condition, but again this appeared largely to be a parental diagnosis, rather than a psychological or psychiatric diagnosis. What appeared to be taking place was that the mother’s ability to present her own perceptions in such an effective way resulted in Services being largely focussed on managing the extreme behaviour rather than understanding what the children, particularly Sibling 2, were expressing and trying to help them and their carers reduce the causes of the anxiety. Why it proved so difficult for professionals to take a step back from the concerns of the mother will be considered further in this section.

4.4.6. The mother’s relationships with other men was also of some concern to various professionals. She was open about using the internet to contact and initiate relationships with men. Despite her ill health preventing her from taking her children to school, she was nevertheless able to visit one of these men in Kent at weekends. Some of the professionals were uncomfortable about obvious indicators that the mother was very sexually active and that this was not kept away from the children but was in fact something she would openly talk about in front of them as well as to professionals. The mother considered that her
relationship with Sibling 1 was like that of a friend, something which both she and the grandmother saw as a positive. One of the professionals, who was very worried about lack of a proper parenting relationship from the mother to Sibling 1, described never having heard the mother talking to Sibling 1 about anything other than who they fancied, which bands they liked and boyfriends.

4.4.7. There was also concern for some about the mother’s unwillingness or inability to act on advice or make changes to her parenting, the impact of which will be considered further in Section 5.6. Whilst some believed that the mother could make changes, there were also those who were frustrated that agreements to make those changes or to follow through on plans were short-lived. The conclusion of one of the workers who had significant contact with the family was that mother ‘had the ability to take on information but didn’t follow through. Her needs outweighed everything else.’

4.5. **The adults in the family: The Grandmother**

4.5.1. What has emerged during this Review is that the children’s maternal grandmother played a much more significant role in the family than was always understood. Certainly, some of the professionals were very aware that the grandmother provided a high level of care and practical support in the home. She was a regular attender at meetings, would take the children to appointments and was known to be very supportive of her daughter.

4.5.2. Grandmother told the Review that she helped her daughter out daily as she was not able to do heavy housework because of her heart condition. Grandmother would arrive early in the morning, tidy the house, help get the children into school, do all the decorating and do the shopping when her daughter wasn’t well enough. Grandmother shared her daughters’ views of the family situation and said that they two of them discussed all the decisions. She confirmed the view that the mother only needed help with Sibling 2 because of her medical problems.

4.5.3. On occasion Grandmother’s parenting style clearly caused some professionals concern. From her own description to this Review she took a quite robust approach to parenting. A better understanding of how much of the practical parenting was being undertaken by the maternal grandmother, what influence she had on the approach to parenting and how the children experienced her in that parenting role, should have been a significant part of an assessment of this family.

4.6. **The adults in the family: The Father**

4.6.1. After the parents separated it appears that the father continued to have a significant level of involvement with the children. Records from the different agencies are not always clear about the level of involvement he had, and he was viewed by several of the agencies as very much on the periphery of the family. It is now apparent that he actually had significant contact with the children. The services that were offered to the father however, were
predominantly for him as an individual rather than as a member of a family. As with the mother, there was no detailed assessment undertaken regarding his role as a parent and no chronology that would have led to a better understanding of his history.

4.6.2. There was information that the father had experienced mental health problems and was regarded as vulnerable by mental health services. The father had intermittent periods of contact with his GP and mental health services prior to and throughout the children’s lives. In 2006 the mental health Trust (NSFT) assessed the father as having a moderate learning difficulty and recorded that he had a long history of depression and had himself experienced abuse as a child. He spoke of being anxious and scared about being a father due to the way his own father had treated him. He said that he was going to attend parenting classes and gave his permission for his information to be shared with his GP and Children’s Services.

4.6.3. The father had moved out of the home in 2006 following the incident when Sibling1 complained about having washing up liquid put in her mouth and also made what appeared to be allegations of sexual abuse by both the father (her stepfather) and her brother. The focus of the response by Children’s Services and the Police at this time appears wholly inadequate. Children’s Services records suggest that attention was only on the washing up liquid issue and on the father’s depression and mental health. It was said that he should not have any unsupervised contact until his ‘mental health issues had been addressed’. It appears from NSFT’s records, that he was in fact referred to and assessed by them, though there is no reference to this in Children’s Services Records.

4.6.4. The mental health practitioner subsequently contacted Children’s Services to inform them that the father was planning to return to the family home and to discuss his risk and treatment. The records then state that the Social Worker said the case was closed and that in any event she would not have been willing to discuss the father and would not accept any information from the mental health service about him. Eventually the father returned to the family without any record of an assessment or obvious involvement of Children’s Services.

4.6.5. Given the passage of time it has not been possible to reach any specific conclusions as to why Children’s Services responded in the way they did to these events. Both the absence of any serious follow up of the allegations of a sexual nature and also that the father simply returned to the home without any further assessment would have been considered very poor practice at that time, as it would be today. If an assessment took place but was not recorded, then this would have been equally unacceptable as it would have meant an important source of information was lost.

4.6.6. The Police investigation was equally poor. No interview was conducted with the father and no crime was recorded. Norfolk Police have described a significantly under resourced Child Abuse Investigation Team during this and poor data recording systems, which might provide some context to the lack of a robust police investigation.

4.6.7. It is not the case that there is direct causal connection between being the victim of abuse and becoming an abuser. However, the knowledge that the father
himself had experienced childhood abuse, combined with his own stated anxiety about being a father, should have been recognised as a significant factor in the assessment of his parenting capacity, including any potential risks he might pose. That this information was not accepted by Children’s Services at that time was a fundamental error.

4.6.8. It is apparent that the father was felt to be someone who was vulnerable and who himself probably had learning difficulties, “he attended in physical form, but did not add much to the sessions.” There was a general sense for example in CAF and Child in Need meetings that he ‘appeared to do the right thing’ although there were also occasions when he would become very angry and on at least one occasion was threatening to a worker.

4.6.9. With the benefit of hindsight, we can now see that this picture of the father was at best very limited, at worst fundamentally mistaken. More than one of the professionals has since reflected that they were taken in by the father, that perhaps they were groomed by him. The siblings who spoke to the Review talked about professionals being taken in, ‘brainwashed’ by the Father. Sibling 1 particularly felt that even not knowing about the sexual abuse, it should have been obvious that given his mental health problems the father was not a good parent. And Sibling 2’s perception about her father’s apparent problems is humbling: “Dad’s ADHD was not an excuse to be a jerk. He would use anything as an excuse”.

4.7. **The adults in the family: Older Sibling**

4.7.1. Older Sibling was also a significant part of the family at this time. There was information available during the key period covered by this review that Older Sibling had a complex history and was a young person with a number of serious difficulties including anger management, and who had also been assessed as having ADHD. An allegation of rape had been made against him in the past and there were other indications of worrying behaviour. He was referred to CAMHS on more than one occasion and was understood to have been traumatised by a serious fire in the family home when he was younger.

4.7.2. What professionals saw was a complex and at times contradictory young person. One of the family support workers described Older Sibling as ‘charming, polite and articulate”, but also said that he often appeared as if he had the weight of the world on his shoulders. Others witnessed him being quite authoritarian, even intimidating with the younger children and assuming a ‘man of the family’ role after the father left. There is information about an at times very difficult relationship between Older Sibling and Sibling 1 with a lot of angry arguments. As was the case with the parents, what was missing was a joined up understanding of Older Sibling, his own experience of being parented, and what part he played in the way this family worked.
4.8. Understanding the children as individuals

4.8.1. One result of the overwhelming emphasis on the family’s story on what was wrong with the children, was that it seems to have made it difficult for the agencies involved to gain a proper picture of the needs of all four children. Sibling 3 and Sibling 4’s views and voices are largely absent in records and they would frequently be sent upstairs when Social Workers or others visited. Whilst considerable support was brought in to help Sibling 1 and Sibling 2, the younger children were not identified as being a problem from the parental perspective and as a result of this they did not attract the same sort of professional attention.

4.8.2. Sibling 4 was identified as having special educational needs as a result of which she was eventually transferred to a specialist school. There had been a range of concerns about Sibling 4 as a young child, in particular including early failure to thrive. However, for much of the time the focus for professional intervention was predominantly on her educational needs and she was not subject to the intensive attention or support that was being provided for her older sisters.

4.8.3. Sibling 3 in particular remained largely unknown within the timescale of this review. She was described by school staff as quiet and compliant: “she was missed – she was so good she went under the radar. She was doing everything right.”

4.9. Indicators of Sexual Abuse

4.9.1. As is identified in the narrative section of this report, there was information about previous allegations of a sexual nature within this family that could, or should, have triggered much greater concern about the children’s safety. This included separate allegations made by two of the children in 2006. Although it is outside of our prime-time period for analysis, one of these allegations links to a concern which has also been raised specifically by the family.

4.9.2. The mother, Older Sibling and grandmother believe that statutory authorities in Norfolk should have been aware that there had been an allegation of non-recent sexual abuse against the father and another family member when they were in another area of the country. The mother told the Review that the father had asked for a copy of his records from a period when he was in the Care of another Local Authority. These notes were apparently heavily redacted, and the mother and Sibling 1 believe this must have been because of this allegation. As a result, they question why the originating authority did not share this information with Norfolk. In fact, at the time the allegation was made in 2000 the records show that the father was not living in Norfolk and was also not known to have any children. The authority who received the information did pass on their concerns in relation to the other family member who lived in another county about whom the allegation was made and who did have children.
4.9.3. Intelligence about this allegation was also provided to Norfolk Police by another Police area in 2006 when they were investigating the allegation of possible sexual abuse previously referred to in Section 5.7. There is no evidence that the Police told Norfolk Children’s Services about this allegation which they undoubtedly should have done. It is particularly concerning in that the person who raised the allegation had gone to Children’s Services in the originating county specifically because she was aware that the father had children. There has been clear recognition by the Police that this was very relevant information that should have been considered. The only explanation that is available to us remains the limited resources in the police Child Abuse Investigation team at that time.

4.9.4. It is not clear if Norfolk Children’s Services were aware at the time that the father had been in care in another area, and there is no evidence that Norfolk was aware of the allegation made against him. Had it been known the father had been subject to Care this might have at least triggered a greater level of consideration of his role in the family. Had Children’s Services also been made aware of the allegation, then it would have been reasonable to expect that further enquiries would have been made. As this was an allegation which had not at that time led to a criminal conviction, it is not possible to judge what impact this would have had, but good practice would have been to undertake a risk assessment. Whatever that assessment concluded it might, if nothing else, have alerted professionals to the possibility of sexual abuse as an explanation for behaviour and difficulties within the family.

4.9.5. A detailed analysis of the chronology provided by agencies in relation to this family identifies time and again both specific references to incidences of sexual abuse and to signs and symptoms which should trigger consideration of child sexual abuse within the family. These included:

- Children talking about sex using adult language, or in a context inappropriate to their age and development.
- A pattern of children running away from home and relationships with older friends and boyfriends.
- Bedwetting
- Inappropriate comments or physical closeness to professionals
- Simulation of sexual behaviour
- Children wearing sexualised clothing
- Concerns raised by neighbours
- Self-harm and suicidal thoughts.

4.9.6. These and other signs, including the extreme behaviours already described, were present throughout the years under consideration and related to all four siblings as well as to at least one of the older siblings. An individual professional might only have been aware of some of these concerns and might not themselves have the experience or expertise to assess what such behaviour signifies. Nevertheless, there are some simple established tools that can be used to consider whether some of these signs, for example use of sexual language, are of concern given the child’s age.16 Unfortunately

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16 Brook Sexual Behaviours Traffic Light Tool
although many professionals were concerned about the behaviour, there is no clear evidence that agencies were talking openly about the possibility of sexual abuse in the family and therefore there was no consideration as to how to assess that behaviour. Practitioners from the Family Support Unit told the Review that sexual abuse was one of the issues they considered and one of the actions they took was to talk to the children about ‘safe adults’ who they could talk to. Nevertheless, no formal referrals were ever made by any of the agencies and there was no reference to sexual abuse of the children as a possible concern in any of the service records.

4.9.7. Many of the professionals were worried about the parental boundaries within the home. There was a widespread view that very poor boundaries were in place. All the children had access to the internet and their mother’s Facebook page as well as films which were inappropriate for their age. Sibling 2 said that when she was not at school she was at home watching the television, including programmes with a high content of violence and sex. The mother appeared to have no boundaries as to what she would discuss in front of the children, where the children slept and what sexual activity they might witness. Practitioners from CAMHS described Sibling 1 being ‘overwhelmed with issues about Mum’s health, financial problems and relationship issues – there did not seem to be any moderation of what was discussed with her.”

4.9.8. It is not that all professionals were unaware or unconcerned about these signs, but where they did have concerns their attention became focussed on other explanations. In particular, there were quite significant concerns that Sibling 1 was at risk of Child Sexual Exploitation (CSE), given the time she spent away from home and some of the people she was known to be friends with. Assessments took place regarding her risk of CSE, assessments which perfectly reasonably concluded that she was at risk and which she herself now agrees with. Safety measures were also put in place, such as the Child Abduction Notice. The response to her risk of CSE was properly managed. However, unfortunately this did not lead to a re-examination of what might be happening within the family that was making her so vulnerable.

4.9.9. There is also evidence that the mother at times presented explanations in relation to allegations of sexually worrying behaviour and that these explanations appeared to be accepted. Examples included:

- When a CAMHS worker was told by Older Sibling that the father had ‘made a pass’ at one of his siblings. CSC records state that mother had discussed this with the father and he had denied it. The mother took the view that as his sibling did not want to go to the police that it was not true.
- When Older Sibling was alleged to have raped another child, the mother was considered to be acting protectively in assuring social workers that he would not be allowed to be alone with this child or with any of his siblings
- When the mother was asked in 2014 about one of the siblings simulating sexual behaviour, she ‘seemed unworried’ and provided various explanations including that the child must have seen the older brother and his girlfriend together or that maybe she had seen something on the internet.
4.9.10. The Older Sibling told the Review that he believed one of the workers had been in the father’s home on one occasion and failed ‘to spot’ some abusive behaviour towards Sibling 2. No other information has been provided to the Review to confirm that this in fact took place. The information given to the Review was not of a specific nature. It was not being suggested that the worker was complicit. In the absence of any further information to support this suggestion the Review would not be justified in making any judgement about the worker concerned.

4.9.11. Disclosure: In their conversations with the Reviewer and Board Manager, both Sibling 1 and Sibling 2 said that they had not felt able to tell anyone outside the family about the sexual abuse. Sibling 1 talked very specifically about being threatened by the Father not to tell. She recognises that there were people who might have listened to her, but she did not feel able to say anything. Sibling 1’s experience of CAMHS and their apparently negative description of her was for her a reason why she would never talk openly to professionals. Given this context and the potential practice implications, further information was requested from the Norfolk and Suffolk NHS Foundation Trust responsible for the CAMHS service.

4.9.12. Sibling 1 was referred to CAMHS on 3 occasions, once in September 2013 and twice in 2014. The records for this period have been retrieved by the Trust. No records or letters have been identified that refer to Sibling 2 in the terms that she described, i.e. as a ‘manipulative attention seeker’. A 4 page letter outlining the assessment in December 2014 and referencing CAMHS previous contact with Sibling1 was sent to the GP. This letter provides a detailed and non-judgemental summary of Sibling 1’s assessment which she attended with her mother. The assessment concluded that she was not suffering from any mental health disorder, but that her difficulties related to her emotional and social situation. It included a detailed analysis of any risks relating to self-harm or suicidal thoughts concluding with Sibling 1’s agreement that she did not have active suicidal intentions. An opportunity to speak to the Mental Health Nurse on her own, was declined. This is not to say that Sibling 1’s response is not based on a genuine belief, but the assessment provided does not reflect the negative judgement that Sibling 1 remembers.

4.9.13. Sibling 2 told her friend what was happening to her and thought about telling other people outside the house, like an older sister or a friend’s mother, but never actually did. Sibling 2 told us quite clearly that she repeatedly told her mother but to no effect. What is powerfully apparent is that as soon as Sibling 2 felt safe and was out of the family, she not only found her voice but was heard. Sibling 2 wanted to tell and wanted to be removed. Sadly, although she was telling at the top of her voice by her behaviour, professionals, many of whom were very empathetic and worried about the children, some of whom were very knowledgeable about sexual abuse, could not understand what she was saying. It should be noted here that this Review has found no corroborative evidence to suggest that Sibling 1 was influenced in making disclosures by any of the professionals.
4.9.14. Whilst the absence of disclosures can create real difficulties in pursuing criminal proceedings, child safeguarding systems should not be reliant on direct disclosure. Research has consistently shown how difficult it is for children to verbally disclose\(^\text{17}\) and further, how rare it is for them to disclose any form of abuse to professionals. Instead professionals need to be alert to the different ways in which children may be telling about their experiences. Cossar et al\(^\text{18}\) describe this as a “spectrum of disclosure” which has four aspects:

- hidden
- signs and symptoms
- prompted telling
- purposeful telling

**Prompted telling** is likely to follow a sensitive response from a professional who has recognised signs and symptoms, or a gradual development of a trusting relationship with a professional over time.

**Purposeful telling** requires the child to understand what is happening to them and deliberately approach someone, which is likely to be particularly difficult especially when the abuse is taking place in a family setting, which creates particular barriers for children in disclosing.

4.9.15. There are indications throughout the story of each of these children that they were telling, but not being understood. It is widely recognised that this is a common experience for many children “the evidence….demonstrates that accessing help for child sexual abuse in the family environment, from both statutory and not-statutory services, is largely dependent on a disclosure”\(^\text{19}\). There is further evidence that the younger the child the more difficult it is for them to disclose. A key challenge to the multi-agency partners is therefore to shift that burden of disclosure away from children and develop a safeguarding system which is not reliant on children speaking, but has the ability and confidence to take that burden from them.

**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.

### 4.10. Why was it so difficult to see what was happening?

4.10.1. It is one thing for a Serious Case Review to be able to analyse the complexities of this family with the advantage of all the information that is available to it, including the extent of the abuse now known. It was evidently much more

\(^{18}\) Cossar et al (2013:v)
\(^{19}\) OCC (2015:34)
difficult for the professionals involved to confidently identify and name what was happening. Consideration as to why this was so difficult has been a major thread throughout this Review, including with those professionals involved at the time, many of whom have evidently struggled to make sense of why they could not see what we can see now. The conclusion of this Review is that there were a number of factors and distractions that were in play and that the response to this will need to be thoughtful and nuanced.

4.10.2. The very complexity of the family’s problems, the effectiveness of the way the children’s medical and behavioural problems were presented to professionals and the demands put on professionals to try to deal with these problems, undoubtedly had the impact of confusing and distracting from the reality of the sexual abuse, as well as the cumulative impact of the neglect. For several of the frontline staff the amount of work that was required to manage the presenting problems of school avoidance and difficult behaviour was extremely high, leaving little time or thinking space. The school safeguarding lead for example described the family as being ‘all day, every day’; of regularly spending an hour simply attempting to coax Sibling 2 into class; of having to prise her off the radiator. She felt very supported by her Head teacher and they spoke regularly about managing the situation. But with hindsight she could see that they had been focussed on managing the daily pressure, not taking a step back and reflecting on the whole situation.

4.10.3. What undoubtedly was primarily in the mind of all the professionals involved was the existence of neglect within the family. It was also ultimately neglect, specifically in relation to Sibling 1 and 2’s parenting and lack of school attendance, that was the focus of the threshold for Care Proceedings. The predominance of neglect in relation to the children however, seemed to get in the way of professionals considering whether they could be experiencing other forms of abuse. That child sexual abuse was not also considered reflects both a local and national picture in that it is significantly underreported and provides the reason for less than 5% of Child Protection Plans.20 Evidently child sexual abuse can be difficult to see and, when it is seen, it is often identified only after children come to the notice of statutory services for other reasons, including neglect.

4.10.4. Although there is no simplistic causal correlation between neglect and other forms of abuse, including sexual abuse, there is recognition that a significant number of children do experience more than one form of abuse. Specifically there is ‘enough evidence for us to be certain that neglect and IFCSA (intrafamilial child sexual abuse) do co-occur.'21 The evidence as to the degree of overlap and why this might be the case is at present limited. Nevertheless, the same research suggests that ‘potential explanations’ may be linked to the vulnerability of children who are experiencing neglect and the quality of parent-child relationships. The degree to which professionals are alive to the possibility of sexual abuse being hidden behind other forms of abuse is difficult to tell. However, the experience of this case, involving a very significant number of agencies and professionals over many years, would

20 Alcock (2016:7)
21 RIP (2016:8)
suggest that this was not something that was a routine consideration either at an individual level or organisationally.

4.10.5. Another factor that has emerged, quite directly from some of the professionals involved, is a lack of confidence about working with sexual abuse. Whilst some agencies and staff felt more confident about this area, there was also a recognition that they had not ‘named it’ and this raised questions as to why. Some professionals felt that there was quite a widespread lack of confidence in talking both to children and to other professionals about sexual abuse. They identified that this was linked not only to professional knowledge and skill but also discomfort, personal experience and a wish not to make moral judgements. Several workers had ‘gut feelings’ that something else was wrong but appeared to have suppressed those feelings, or not said anything to colleagues as they felt they did not have evidence.

4.10.6. Several of the professionals and their agencies identified a lack of an adequate knowledge base across the agencies, including a lack of identified individuals with expertise who could provide advice and specialist support. This was contrasted with the recent development of the Harmful Sexual Behaviour Team who were felt to have had a significant impact on awareness and were also a trusted source of advice. Similarly, there was a perception that Child Sexual Exploitation awareness and practice had improved in recent years in Norfolk, again due in part to a more specialist approach. A number of professionals however felt that there was less awareness of familial child sexual abuse and that to some extent the recent focus on CSE had overshadowed abuse within the family. Whilst more recently Child Sexual Abuse has become a priority for the NSCB, this was not reflected in direct practice during the period relating to these children.

4.10.7. Recent research in relation to Social Workers’ confidence in working with child sexual abuse, whilst based on the social work profession, nevertheless provides some learning for all partners and chimes to a significant degree with the experience of this Review. The following were identified as some of the difficulties they were faced with:

- The rapidly changing nature of environment in which sexual abuse of children is taking place (CSE, internet, sexting etc) made it difficult for Social Workers to keep pace.
- Social Workers had very limited training on CSA during qualifying training and many felt unprepared for the work.
- Limited workplace-based training, which was predominantly focused on understanding sexual abuse, rather than direct work with families.
- Lack of understanding of healthy sexual development in children.
- Social Workers who had no direct experience being allocated to work with cases involving sexual abuse.

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22 Harmful Sexual Behaviour: Sexual behaviours expressed by children and young people under the age of 18 years old that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards another child, young person or adult’. (Hackett 2014 Children and Young People with Harmful Sexual Behaviours).

23 Martin et Al (2014)
• Lack of adequate time for reflective supervision or peer support.

The overall picture from this research was too often of those Social Workers operating without the support, time, knowledge and training required to help children experiencing sexual abuse in their families. Each of these aspects can be seen at times within different agencies in relation to this Review.

4.10.8. Working within the field of safeguarding and child abuse places very high demands of any professional, yet the resulting emotional and personal response is something to which less attention is often given. The work requires professionals to routinely deal not only with the family’s stresses and the children’s distress, but also their own emotional reactions. Further if they are to really understand what might be happening in a family they need to seek out information confident that “whatever they unearth, including their own feelings of horror, fear and despair will be managed.” 24(Reviewer’s emphasis). This was a household where the ‘emotional and sensory overload’ 25 that the professionals were required to deal with was at the highest level. This Review has been able to have some, however limited, insight into the way in which that context is likely to have impacted on professionals and their roles; their ability to engage in a more in-depth way with the children and better understand their experience; their capacity to think critically and to question their own hypotheses.

4.10.9. What is identified in Ferguson’s research is that Social Workers who seemed not to see or meaningfully engage with children in some situations, responded perfectly competently elsewhere, evidencing that there was something about the particular set of circumstances and pressures in which they were working which impacted on their ability to work to their best standards. How well professionals feel able to manage their work in these complex situations will be a result not only of their individual strengths personally and professionally, but also the support they receive to make sense of what they are seeing and the demands and expectations of their organisations – for example in relation to workloads, priorities and bureaucratic requirements.

4.10.10. Whilst there are some potential ‘quick fixes’ such as training or introduction of new assessment tools, unless there is a fundamental focus by services on the emotional content and the impact on critical thinking for those working in safeguarding, children’s needs in complex situations will continue to be misunderstood. If safe practice is to be more consistently ensured, practitioners need to be provided with “an organisational culture in which they routinely receive opportunities to critically reflect on their experiences.” 26 Skilled reflective supervision is an obvious starting point for those professionals with significant safeguarding responsibilities. However, formal supervision is not the only means to support frontline staff. Other approaches whether that be providing specialist accessible support and advice, enabling joint working in complex cases, reviewing the range of work

24 Burton and Revell(2017)
25 Ferguson (2017)
26 Ferguson (2017:1021)
being undertaken by individuals and what impact this has on their capacity to focus on safeguarding. Ultimately what is required is an organisational culture which views its frontline staff as its greatest resource for which it will provide maximum support.

**Recommendation 2**

The NSCB and Partner agencies review the support provided to frontline 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.

### 4.11 The Response to the Family’s needs as they were understood: the interventions

4.11.1. The professional view of the family was reflected in the interventions that were put into place. In practice the very existence of those interventions at times contributed to the difficulty in properly understanding the family and the children’s experience. Predominantly the actions taken reflected the view, although this was not shared by all, that this was a family struggling to get it right. The focus was, to a significant extent, on supporting the mother with the various parenting difficulties she faced. This was not that the children’s needs were ignored, but because they were so significantly understood through the mother’s lens, the impact was that their actual needs largely went unmet.

4.11.2. The responses to this family, although significantly affected by the way they were understood, also highlighted some fundamental problems within the safeguarding system during this period, particularly within the statutory role of Children’s Services. These systemic problems will be considered within this section.

4.11.3. The analysis of responses to this family prior to 2011 has not revealed significantly different learning than has been identified between 2012 and 2015. As a result, the examples of practice used in this section are predominantly drawn from the Review’s main period for consideration.

4.11.4. Some statutory assessments were undertaken by Children’s Services but until Sibling 2’s disclosure these remained focussed on the issues as identified in Section 5 of this Review. As described in the 2014 Core Assessment the purpose was: “to improve routines, home conditions, school attendance, boundaries and behaviours”. In the earlier years, including during the period when some of the older siblings lived at home, there was an absence of effective assessment. Any interventions that were identified generally proved ineffective in engaging the family in any meaningful way or in leading to change. Two Initial Assessments were completed in 2012 both in response to events relating to Sibling 1, the first following an allegation of rape by another young person, the second due to her suicidal thoughts and episodes of going missing. Neither of these resulted in any further action and the assessment is heavily reliant on the mother’s perspective. It was not until the
Core Assessment completed in March 2014 that it was decided to initiate S17 Child in Need Planning.

4.11.5. Although the siblings and their family had a considerable level of contact and were subject to a high number of referrals from various agencies to Children's Services, including from Police and schools, none of the children were subject to Child Protection Procedures prior to Sibling 2 making her disclosure in October 2015. Irrespective of the unrecognised sexual abuse, it is clear that Child Protection Planning should have taken place at a much earlier point given the level of neglect the children were experiencing and the visible distress that they were exhibiting. Several of the professionals specifically expressed their view that the children should be in Child Protection Proceedings, but felt they were not heard, to some extent because of their perceived lower status. For much of the period from 2011 onwards the children were instead subject of a CAF led by the school. Then from 2015 the children were subject to Child in Need planning led by Children's Services. During both periods the focus of multi-agency activity was as, outlined in Section 5, largely on dealing with the children’s behaviour and school attendance.

4.11.6. What is immediately striking in relation to the response to this family is the extent of service involvement and the numbers of agencies who became involved. A large number of professionals were going into the home at various times, and numerous referrals were made for family members to other services. Often children or adults would be re-referred to services that they had been to before with little evidence of progress, or where it was evident that they had not previously engaged. Whilst the mother would agree to referrals her real commitment was often questionable. As she said about contact with one agency intended to help with Sibling 2’s problems she felt she was “being taught to suck eggs”. When there was a lack of engagement with one service, alternative services were offered. This was especially noticeable for Sibling 1, who was referred to one organisation for support after another, without any evident understanding as to why she was not engaging or what she might find helpful. As one professional said to the Review, they were “throwing everything at the situation, not really knowing what the underlying causes were, but let’s keep trying”.

4.11.7. Some services were never able to move from the assessment stage to the point of implementing planned work, often because of missed appointments and other difficulties in meeting with family members. For example, the Community Paediatrician had made a referral to the ADHD team for Sibling 2, who attended with her mother, father and occasionally maternal grandmother. The team clearly had significant concerns about Sibling 2, but also about the nature of the parenting she was receiving “Mother always said that she was trying really hard, but there was never any evidence of action taking place”. Sibling 2 would cling to her mother and attempts to see her alone were

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27 Child in Need: A Child in Need Plan, or CIN, is a multi-agency plan put in place with the family under Section 17 of the children Act when a child is in need of extra support from different agencies, but is not assessed to be at risk of significant harm.
unsuccessful. Ultimately the service, whose model is to work with the whole family, concluded that in the absence of parental willingness to make changes, continuing the service was not worthwhile.

4.11.8. The volume of services involved, in the absence of a strong lead professional, meant that there was no clear track to show what had been achieved, and in particular to what degree the parents were actively taking part or seeking to make change. At times records are contradictory as to whether the parents had engaged with a particular service and it is difficult to identify an audit trail. What seemed to be absent was a clear review process and reflection on what was or was not working. Equally there is limited evidence of strategic or long-term planning with most of the interventions being focussed on dealing with immediate behavioural problems or with the children’s medical diagnoses.

4.11.9. With regard to the CAF process, the experience of the professionals working with this family reflects inherent weaknesses that have previously been identified regarding the CAF, in that it lacked independent oversight or a clear framework for review. A previous SCR made a finding about similar problems for professionals working within a CAF during the same time period. The CAF system has now been replaced by the Family Support Process (FSP) in Norfolk. Ofsted’s inspection report in October 2015 and in 2017 found improvements in Early Help of which the FSP is an important part.

*Early help services, provided through a range of interventions, are increasingly reaching children when needs are first identified and result in effective support. When risks escalate, children’s cases are appropriately stepped up to children’s social care. However, the recording within the family support process is of inconsistent quality, and the processes to oversee how quickly children are seen and to measure impact are underdeveloped. The local authority recognises these weaknesses and has already commissioned a new electronic recording system to strengthen record-keeping*[^28].

In this context it would not be proportionate for this review to make recommendations regarding the FSP process.

4.11.10. Two of the organisations who responded to referrals, the Housing Unit’s, Family Support Team and the Local Authority’s Targeted Support Team, were involved in very intensive work with the family. Staff from both teams clearly worked very hard to support mother and the children, at times visiting the home daily as part of attempts to get Sibling 1 into school. Whilst it was evident from meeting some of the practitioners that they brought considerable personal skills to the work, in terms of their role, training requirements and status they were in a difficult position from which to challenge the approach being taken. Staff felt frustrated that were taking on a role that they felt should more appropriately be done by Social Workers and described a lack of clarity about what the work plan was. The Family Support Team concluded after a period of almost 6 months that they were not making progress and withdrew from their involvement specifically to

[^28]: Ofsted (Oct 2017:9)
indicate to Children’s Services that there needed to be a different approach. Similarly, the Targeted Support Team worker identified within 3 months that there was no meaningful change.

4.11.11. At the same time one of these practitioners, who worked with the family for nearly 9 months, felt that she was just beginning to get to know the mother and to have an understanding of what might be at the cause of the problems. She was particularly concerned about the adult sexual behaviour in the house and the mother’s approach to relationships. Her sense was that this family required a much longer working relationship in order to truly understand what was taking place. What is evident here is that the lack of a consistent primary worker who had a good knowledge of the family and could take decisive action when required, was a significant contributor to the indecision and delay that followed.

4.11.12. The lack of an effective means to engage both Sibling 1 and Sibling 2 with services that could have understood and responded to their level of emotional distress and trauma is of significant concern. Both children were displaying highly worrying, sometimes extreme behaviour, including violence, self-harm and suicidal thoughts yet there seemed to be no place where they could be enabled to feel safe enough to talk. Although both children, and two of the older siblings, were at various times referred to CAMHS, neither met the threshold for that service which at Tier 3 is based on a patient having a diagnosable mental illness. The assessments of the children’s needs given the existing threshold is not disputed. However, for children such as Sibling 1 and Sibling 2 with very high levels of emotional distress, the resulting lack of access to skilled psychological therapies created a significant gap.

4.11.13. The commissioning of mental health services for children and the narrow way in which thresholds are set, is a cause of significant concern at a national level. The current position being described as a crisis in a recent report by the Office of the Children’s Commissioner.

4.11.14. Sibling 1, as she herself powerfully described, was reluctant to the point of hostility to talk to professionals. Taking into account what we know about the number of professionals who had been in and out of her life, the pressures within her family and the knowledge that she was carrying about her family, it becomes understandable as to why she might have felt this way. Her prime experience of professionals was that they always wanted to make her do things or tell her how she should behave. Her description of simply needing someone who was there for her, someone who would listen and give advice if asked is completely consistent with what we know about young people’s perspective. What was on offer at this time however, was almost

29 Child and adolescent mental health services (CAMHS) deliver services in line with a four-tier strategic framework. Tier 1 being general advice and support provided by non-mental health specialists, Tier 4 for children and young people with the most serious problems needing highly specialised help.

30 OCC. (Oct 2017)
entirely task focussed, rather than relationship focussed and Sibling 1 very clearly rejected that approach.

4.11.15. Research and Serious Case Reviews have regularly identified in recent years the need to pay considerably more attention to working with adolescents. Sibling 1 told this Review very clearly what she needed from professional support and this is reflective of what we know from other young people:

i. ‘Someone who listens and then understands’
ii. ‘Someone who does not judge’
iii. ‘Someone who acts and has a plan’
iv. ‘Someone who spends time with you’
v. ‘Someone who talks with you and not at you’
vi. ‘Someone who has the information that you need and knows about the different options’
vii. ‘Someone who gave you choice’
viii. ‘Someone who focussed on all your needs and not just your special problem’

Consultation with a group of 16–17 year olds

4.11.16. The sparsity of specialised services skilled in working with adolescents who may be experiencing abuse or neglect alongside the difficulties that many other services appear to have in working effectively with this age group, is a nationally recognised problem, not simply an issue for Norfolk. It would be wrong to presume that had one of the professionals developed a trusting relationship with Sibling 1 that this would have inevitably enabled her to disclose the abuse that was taking place. Nevertheless, the lack of such a relationship represented a significant gap in the support and help that could have been offered to Sibling 1. NSFT which provides the CAMHS service has provided information about a range of work it is involved in, including an independent review of safeguarding within CAMHS and also recognised that there could be further improvements to their approach to working with adolescents. However, the needs of this group can only be met by a multi-agency approach and therefore this is subject to a recommendation.

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.

4.11.17. The Police’s response to this family in the earlier period covered by this Review has been clearly recognised as not meeting acceptable standards in investigating allegations of sexual abuse and in terms of the police’s responsibilities to safeguard children. Norfolk Constabulary have made a number of important changes since this time, including a significant increase in the Child Abuse Investigation Unit, adoption of a new data recording...
system and creation of a Complex Case Manager role to ensure the efficient running of complex child abuse investigations and responsibility for working with partner agencies in relation to safeguarding. One further area of concern was the response to the high numbers of Police call outs to the family. Although Children’s Services were routinely notified, no consideration was given by the police to establishing what action had been taken as a result, nor was a referral triggered in relation to the accumulation of ‘minor’ incidents or the concern escalated. Current processes in the MASH now involve the Police identifying such repeated concerns and forwarding them to Children’s Services colleagues for assessment. Norfolk Constabulary have identified a number of other learning points as a result of their involvement with this family, including regarding their response to episodes when Sibling 1 was missing. Relevant recommendations are contained in Appendix A of this report.

4.12 Drift

4.12.1. In considering the response of agencies to this family and the impact this had on the outcomes for the children, what is absolutely central is the degree of drift in planning and response. We know that generally the longer the period of time that children experience sexual abuse the more damaging this is for that child. What is particularly disturbing here is that we now know that Sibling 2’s abuse by the father actually increased when she was waiting for a foster placement.

4.12.2. Throughout the period considered by this Review the pattern of delay was a constant. Some of the delay arose, as has already been considered, out of the way the family was understood, particularly in relation to parental engagement with professionals. However, in parallel with this were some very significant organisational influences that at times actively prevented key professionals from ensuring their concerns were heard and acted upon.

4.12.3. The first recorded reference to placing Sibling 1 and Sibling 2 in foster care was in February 2014, although it is evident that this had already been discussed with the mother. However, it was over a year later in March 2015 that Sibling 1 was actually placed in foster care and in September 2015 that Sibling 2 was placed. There was considerable frustration felt by some of the professionals at the constant changing of position regarding the plans to move the children into foster placements. The Safeguarding Lead for the School and Targeted Support Team worker particularly described their disbelief in one meeting when a decision to remove all four children was reversed apparently in order to allow the mother to attend counselling.

4.12.4. Some of the delay arose out of finding suitable placements for Sibling 1 and Sibling 2. In any event, this delay was also linked to the fact that decisions about placements were reliant on agreement by the mother, under S20, which on at least one occasion she would not give. Nevertheless, this was not the fundamental problem. What is clear is that two closely linked features overwhelmingly impacted on the capacity of social care staff to make

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32 Ref: OCC (2015:75)
progress. Both of these features were directly related to the quality of service provided by CSC during this period and were:

- Resources within Children’s Services
- Strategic level drive to reduce the numbers of children in care.

4.12.5. In 2013 Children’s Services, had been judged to be inadequate by Ofsted and was made subject to an Improvement Notice which was removed in 2017 when the Authority was judged in need of further improvement to be consistently good, and it is not therefore surprising that some features of the practice experienced by this family clearly reflected the very problems that were identified by Ofsted during this period.

4.12.6. Following the 2013 Ofsted report, the authority was subject to a significant number of changes both in leadership and due to restructuring. One of these restructures, included the separation of Child in Need and Safeguarding into separate teams, which created unintended consequences for the management of some cases. The 2 teams were led by different managers who reported to different Heads of Service. The effect of this was to create an artificial barrier making it difficult in practice for children to be progressed from one team to another.

4.12.7. The workload pressures between 2013 and 2015 were intense. Teams were dealing with very high caseloads, unallocated cases, long working hours, rapid staff turnover and reliance on agency staff. The result was that assessments and work had to be completed under pressure, at times impacting on Social Workers’ capacity to build relationships or to regularly reflect and review the work. At the same time, information on computer systems was often limited. The old paper files, with their rich source of history, were almost never accessed, not helped by being stored out of the county. Although the team managers described trying to prioritise supervision, the reality was that there was minimal time for reflection.

4.12.8. The primary strategic driver at this time was to reduce the numbers of children Looked After by the Local Authority as this had been identified in the OFSTED report as being too high. The intention was to manage the funding of Children’s Services by reducing the number of Looked After Children and children on Child Protection Plans. The expectation was that everything possible would be done to reduce the numbers of children moving into Child Protection or becoming Looked After. Evidence to this Review was that when cases were taken by staff to the Panels which made the decisions about placing children in care, this would frequently result in them being asked instead to try further interventions. The result, as in this family’s case, was not to build in constructive opportunities to create change in families, but to build in delay.

4.12.9. The situation as described here was widely recognised outside of Children’s Services, with other professionals commenting on the pressures on their colleagues in Children’s Social Care. What this has highlighted is the impact that decision making in one agency can have on the wider safeguarding system and the need for an agreement amongst the multi-agency
partnership as to how any risks can be mitigated against. A recommendation has therefore been made as follows: **Recommendation 4**

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

4.12.12 A major programme of change has been taking place and some significant improvements have been made in response to the sort of weaknesses in practice that have been identified in this report. In particular:

- Smaller team sizes across frontline teams which means, leading to smaller caseloads for practitioners and fewer cases been overseen by each manager.
- Child in Need and Child Protection cases are now all held in Family Intervention Teams, with one Social Worker in one team overseeing all children in a family.
- Quarterly summaries are completed on all children open to a social worker to ensure easy to find updates/overviews on cases.
- Introduction of a rolling programme of Systemic Supervision training for all managers
- County-wide implementation of a defined social work approach to intervention.
- County wide training on Child Sexual Abuse for social workers and team managers.

4.12.13. It is clear that there has been a significant improvement in the services provided to children and families by Norfolk Children’s Services, as has been recognised by the recent OFSTED inspection report. Many of the changes are likely to minimise the vulnerabilities in practice being repeated for future families. This section of the Review has focussed primarily on Children’s Services, which is an inevitable consequence of the processes in which the families were involved. However, other services all had a role to play in relation to ineffective interventions and drift, and there is learning for all these agencies, not simply Children’s Services, which will be reflected at the end of this Review.

4.12.14. However, this has also highlighted the impact that decision making in one of the partners can have a significant unintended consequence on safeguarding practice more widely.

### 4.13 The response at the time and following disclosure.

4.13.1. This Review was asked not to undertake a full analysis of the period following Sibling 2’s disclosure but to consider the effectiveness of the multi-agency partnership at the point of disclosure and immediately afterwards. The Review had been made aware of conflict between staff in Norfolk Constabulary and Children’s Services at this time and this was recognised as an episode which might hold wider learning.
4.13.2. A crisis response was inevitable when Sibling 2 made disclosures about sexual abuse in the autumn of 2015. Even though both Sibling 1 and Sibling 2 were by now in foster placements until this point the possibility of familial sexual abuse had not been actively considered. The first disclosure related to one of her siblings. As the child concerned was below the age of criminal responsibility, the Police reasonably referred this back to CSC. A strategy discussion took place, a Social Worker spoke to both Sibling 3 and Sibling 4 the same day and a follow up strategy meeting was then planned for the following Monday. This represented a clear plan of action and is of a standard that would be expected. Whilst, it might not have been described as such, the behaviour alleged given the child's age would come into the category of Harmful Sexual Behaviour, rather than criminal behaviour. Since 2016 Norfolk has in place a specialist Harmful Sexual Behaviour team and practice increasingly has been to access support and advice from this team. In 2015 Children’s Services would have been the lead in responding, but in fact Sibling 2’s further disclosure changed the situation for all the siblings dramatically.

4.13.3. Sibling 2’s disclosure was reported by her foster carer to the Emergency Duty team on Sunday evening. The EDT Social Worker, following discussion with the team manager that evening, checked the records and identified that the children lived with their mother and that father had contact with the children but was at a different address. In the conversation with the manager it was agreed that the Social Worker contact the mother to confirm where the children were and whether any immediate safeguarding action was required before the allocated Social Worker could respond the next morning. The Social Worker phoned the mother who confirmed that the children were with her but did not tell the mother about the disclosures. The information was forwarded to the allocated Social Worker and no further action was taken by EDT as the children were considered to be safe.

4.13.4. What is of concern is that although the records refer to the possible need for both an ABE interview and a paediatric examination, there was no actual conversation with the Police that night. The EDT worker specifically noted that she did not tell the mother that there was an allegation about the father, suggesting that she was aware that to do so could compromise any investigation. At the same time, it was accepted that the Mother would be protective. In fact, the simple fact of telephoning the mother out of hours on a Sunday would have alerted her to the possibility that there was some serious concern and there could be no certainty that the father would not then be told. Standard practice in such situations is to seek advice from the Police as to how the situation can be managed best, minimising any further risk to the children and making sure the Police investigation is not compromised. Whilst there is no evidence to suggest that there were negative outcomes, this clearly created a risk.

4.13.5. A similar situation occurred the following morning when the allocated Social Worker spoke to the mother who appeared anxious as to why EDT had called

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33 Achieving Best Evidence (ABE): Guidance produced by government regarding video-recorded interviews with vulnerable, intimidated and significant witnesses
her the previous night. The Social Worker told her that Sibling 2 had made some allegations, which she could not tell her about. She went on to say that the father should not have any contact with the children. This evidently suggested that the allegations related to the father.

4.13.6. During the course of that day various actions were taken, including a Strategy Meeting and, eventually, identification of foster placements for Sibling 3 and Sibling 4. The Strategy meeting was organised by the social work team and took place the same afternoon, which although this was felt to be too long a delay by the Police Officer, is in line with standard practice and is not subject to criticism within this Review. What is of concern is that no notes of that meeting have been saved within the Social Care records, which is clearly poor practice.

4.13.7. Both the Detective Sergeant, who was the duty sergeant when the disclosure was reported, and the relevant Team Manager in Children’s Social Care describe having quite a difficult disagreement about what steps needed to be taken to remove the children from the household, and most significantly the urgency of removal. The Police position was that they needed the children to be removed immediately, potentially under Powers of Police Protection. This was both to safeguard the children, but also to ensure that any evidence was preserved. The Children’s Services team manager took an equally robust position that it would be better to achieve a planned move for the children the following day as it was her understanding that mother was protective.

4.13.8. Both positions were clearly based on genuine perspectives about how best to proceed. However, the team manager was wrong in her view that the mother was protective as by this stage the records were clearly identifying that Sibling 1 and Sibling 2 had been significantly harmed by their parenting and that managers were concerned about the mother’s ability or willingness to make changes. The team manager has since recognised that had she seen this information she would have accepted the police position without argument. Children’s Services Records of this episode are limited and the manager, although remembering the argument, could not remember details of what happened or why she had not known the information about the mother that was available in the records at that time.

4.13.9. The Police Officer was understandably concerned that the significance of protecting evidence for criminal proceedings was not fully understood by her colleague in Children’s Services. It is difficult to tell, having spoken to both the professionals concerned whether this was a lack of understanding or rather a mistaken view that the mother could protect and a different perspective about the best way forward. What is clear is that these two strong individuals were involved for too much time in an unhelpful conflict that was in the end resolved by the Police Officer taking (appropriate) unilateral action. Whilst both recognised that their personalities played a part in the conflict, it is also the case that these events can be very pressurised and highly emotive and as such disputes of this nature could be repeated. However, it is not the view of the author that, given what are otherwise generally experienced as effective relationships between Police and
Children’s Services, it would be proportionate recommend that this be a major point for learning and recommendation within this Review.

4.13.10. What is nevertheless a cause for concern is that there was a lack of clarity about the importance of immediate liaison between Social Workers and the Police at the point of disclosure. Commitments have been given by CSC that they will seek to raise awareness about this issue.

5 CONCLUDING COMMENTS

5.1. The purpose of a Serious Case Review is to learn from the case in order that improvements to practice can be put in place to help families in the future.

5.2. It is evident that whilst their individual experiences differ, all four children were subject to chronic and complex neglect as well as repeated sexual abuse of the most serious kind over a significant period of time. The long-term impact for these 4 siblings cannot be underestimated and they should have been much better protected. Despite the commitment and best intentions of many of the professionals involved, the reality is that the multi-agency safeguarding system proved ineffective and too slow in its response. The reality that repeated sexual abuse within the family was taking place as well as neglect was only understood at the point Sibling 2 was removed from the home and felt safe enough to tell her foster carer what had happened to her.

5.3. It is unrealistic to conclude that sexual abuse in this family could have been completely prevented. However, the extent of that abuse and its continuation over such a long period of time could without doubt have been minimised. What is clear is that there has been significant reflection and learning within the group of practitioners who worked with this family, many of whom were highly distressed at what had happened and their apparent inability to prevent it.

5.4. Some significant areas of concern, including response to neglect and working with families effectively below statutory thresholds, have been identified here As has been previously noted where there is evidence of recognition of the concern and action being taken, no further recommendations are being made in this report.

5.5. The experience of these 4 children has also highlighted a significant number of learning points for practice. These practice points will be very familiar to many frontline practitioners, but are worthy of repetition given the impact in this case:

- 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.

6 RECOMMENDATIONS FOR THE BOARD

It is important that a proportionate response is taken when considering what action is required as a result of this SCR. It has been a conscious decision not to focus on SMART recommendations regarding the details of policy, practice and structures or to repeat recommendations that have been made previously and are being taken forward by the partnership. Account has also been taken of the very significant changes made by Children’s Services in the recent past as well as the ongoing priority given by the Board to improving practice in relation to Child Sexual Abuse.

As a result it was the strongly shared view of the Review Team, a view supported by the Independent Reviewer, that the focus should be on a small number of recommendations.

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.
APPENDIX A: SINGLE AGENCY RECOMMENDATIONS

Each of the agencies who provided individual agency reports also included a range of learning points specific to their own agency. The following agencies also made specific recommendations for their own agencies.

Norfolk Children’s Services: Children’s Social Care (CSC)

1. Workers must be curious, skilled and experienced in recognising the environment in which familial sexual abuse takes place.

2. Managers must ensure that workers are given sufficient time in the planning of intervention to consider the history of all of the children in the family

3. All workers must explore with parents their experience of being parented and what impacted upon them

4. Workers must not be overly influenced by medical diagnosis

5. Workers must look beyond behaviour and always explore the cause

6. Managers must ensure that actions discussed in supervision are carried out to avoid drift.

7. Managers and workers must keep an open mind and always consider ‘what else might this mean’?

8. Workers should not necessarily take a parent or child’s account of events on face value.

Norfolk Children’s Services: Education

To work in partnership with Norfolk Constabulary to ensure that the NSCB Child Sexual Abuse strategy and the profile of CSA in Norfolk is cascaded as widely as possible to education staff through integration into all Designated Safeguarding Lead training during the Spring and Summer Term 2018.

Norfolk Constabulary

1. If a child is reported missing the Missing Person Coordinator should check the COMPACT system to research if other siblings have gone missing in the past. If another sibling has previously gone missing this information should be shared with Children’s Services so that the situation within the whole family can be taken into account and the need for a strategy meeting can be considered.

2. Consideration to be given, to review the current policy, in relation to a strategy discussion being triggered following 3 incidents in 42 days.

3. When a child goes missing and they have a long term active social worker, the child should be asked who they would like to do their returns to home interview as they may rather it be done by an independent person.

4. Raise awareness around neglect and Police Protection Orders amongst the workforce.
5. Strategy discussions to be held/reviewed by a suitably qualified Detective Sergeant within the MASH

6. Following Strategy discussions where the outcome is single agency (children services) for the case to remain pending, awaiting update from children services. (This is in relation to cases where Children Services are conducting an assessment of families to establish if any criminal offences have occurred.)

Norfolk and Norwich University Hospital Foundation Trust

Staff who are treating adult patients should ask about children at home and childcare arrangements if the adult needs to be admitted. This information should be recorded in the notes and any concerns voiced by either the patient themselves, or by staff, should be shared with the Trust Safeguarding Team.

Norfolk and Waveney Clinical Commissioning Groups

(Recommendations for GPs)

1. Clinical Practice staff should document accompanying adult, parental responsibility and consent where appropriate at all consultations.

2. Clinical staff should use a tool such as the Bio psychosocial assessment to identify the family members and possible impact when seeing an adult with mental health or significant physical health problems. Risk to the patient and others including children should be documented.

3. GPs should hold regular liaison meetings with Healthy Child Programme Practitioners to discuss children of concern. This should include looking at audits highlighting patterns of attendance of concern. The outcome of the discussion should be documented on the child’s record.

4. GPs should not write letters to external agencies at the request of parents without they may be at risk of collusion.

5. Children should be given the opportunity to be seen alone and this offer and whether it was acted on should be documented.

Norfolk and Suffolk NHS Foundation Trust

1. To review the NSFT Safeguarding Children Training to ensure that it remains fit for purpose in light of the learning points

2. To incorporate the Learning Points into the Safeguarding module of the internal rolling programme of Quality Workshops.

3. To promote the Learning Points in the internal Patient Safety Newsletter.

4. To promote the Learning Points at Locality/Service Governances Meetings across the organisation.

5. To review the NSFT Safeguarding Children Policy to ensure that it remains fit for purpose in light of the learning points

The three learning points referred to are:
• The ongoing need to consider the use of the Think Child, Think Parent, Think Family tools/principles, in particular the role of fathers or other key adult males in the family/household.
• The importance and function of professional curiosity.
• The risk associated with caseload drift.

Cambridge Community Services NHS Trust

1. To improve the use of evidence-based assessment tools for example signs of safety and graded care profile
2. Develop an early warning staffing model to indicate when staffing levels are below full complement to facilitate focus on high level intervention and safeguarding work.
3. To improve HV/GP liaison in practice
4. Ensure that health practitioners in the Multi-Agency Safeguarding Hub (MASH) participate fully in the MASH activities and cascade information appropriately to staff in the HCP and also inwardly from the HCP to the MASH to improve joint working
5. Prioritise staff training for neglect and domestic violence
6. Ensure the Graded Care profile is used to assess and evidence neglect
7. Ensure HCP staff are compliant with supervision
8. Review system 1 templates to improve record keeping
9. Complete a record keeping audit annually
10. Develop care pathways and standards related to domestic violence and attendance at A&E
11. Ensure safe and effective transfer of cases between practitioners within the organisation
12. Development of a supervision model based on the signs of safety that encourages practitioners to be curious about the lived experience of the child in the light of the information that is known and received
13. Introduce a method for capturing significant events within the electronic record to facilitate practitioners identifying patterns of events that require further investigation.
APPENDIX B: NSCB Thematic Learning Framework

Learning from Serious Case Reviews: Emerging Themes

- Professional Curiosity
- Fora for Discussion and Information Sharing
- Collaborative Working & Decision Making
- Ownership & Accountability: Management Grip
- The Lived Experience of the Child: Case Specific SCR Learning
- Managing Risk & Uncertainty
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