Serious Case Review (SCR) Briefing 2019

Practice Briefings

Megan

SCR Megan. Megan was a Looked after Child since birth until in 2012 when she was two years old, she was placed with her newly identified Paternal Grandmother (PGM) under a Special Guardianship Order (SGO). In June 2015, Megan was found on presentation at a local hospital to be a victim of neglect, physical abuse and underweight. She had sustained numerous bruising to her body, diagnosed by medical clinicians as non-accidental injuries (NAI). It transpired her PGM, her birth father C and the PGM's partner, inflicted cruelty, physical abuse and neglect on Megan. They were subsequently arrested and charged with offences of assault, ill-treat, neglect, abandon, a child or young person, to cause unnecessary suffering and injury from 2012 until 2015. Her sad account that she never received a cuddle, they did not love her and the emotional and physical abuse she had to endure was despicable and cruel. The defendants were found guilty at court and received substantial custodial sentences. Fortunately Megan is safe and now in long-term foster placement and is thriving.

The SCR Recommendation and Findings

Finding 1.

Recommendation 1 - Gloucestershire CC Pathway for Special Guardianship Orders

'It is recommended Gloucestershire County Council and Gloucestershire Children Social Care and Permanence develop a safeguarding pathway for the application of family members for Special Guardianship Orders. The process will include utilising a Family Group Conference and to apply for an interim Kinship foster placement to allow safeguarding to remain in place whilst a detailed viability assessment of the prospective guardians' capabilities is conducted. This is whether there has been a previous family relationship or not, as it will ensure the best interest of the child or young person for the long-term period is captured, help reduce staff workloads by relieving time constraints, subject to supervision oversight to make sure the process is effective and in compliance with legislation and guidance.'

2. Governance and supervision

There was no consistent management oversight, particularly in early interaction with professionals working with the family and in the assessment and report prepared for the SGO applicant PGM

3. Recognising signs and symptoms of child sexual abuse and neglect

All safeguarding partner agencies must ensure staff are made aware of the signs and symptoms of CSA and know what to do if they are seen or suspected. Staff must utilise the Gloucestershire Neglect Toolkit 2018 in order for practitioners to identify and capture evolving safeguarding concerns at a much earlier stage.

4. Referrals, SGO assessments, Family Group Conferences and sharing information

There was lack of credible risk assessments in the SCR in particular the SGO assessment for PGM's application. Megan's foster carer's view confirmed by the PGM regarding the lack of bonding between the PGM and Megan was not reported to the court. A Family Group Conference earlier in SGO process should have been considered. After the SGO was enacted, signs of neglect Megan

Useful links:

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displayed, the noticeable PGM's attitude and behaviour towards Megan, her failure to engage with professionals and the opportunity for practitioners to consider communicating between agencies and contact GCSC and share information did not provoke safeguarding action. An earlier professionals' meeting or strategy discussion could have considered the wider dimensions of Megan and would have recognised she was not registered with any GP Practice whilst living with her PGM. Regular communication and information sharing between agencies may have resulted in a better outcome for the protection of Megan's health and welfare

5. Child focused and capturing the voice of the Child.

Megan's voice was not substantially heard or captured by practitioners and within the 2017 SCR in her case which, may have been due to limited access to Megan's account given to police for the criminal investigation. When Megan was spoken to by practitioners about being hungry on several occasions, being cold with blue lips and concern for the clothing she wore, these concerns were not progressed satisfactorily. The PGM's response to these concerns was dismissive when challenged but accepted and not explored further. The voice of Megan's was therefore not effectively captured at the time considering the subsequent disclosures she made to police.

6. Record Management

Agency submissions indicated a deficiency in some record keeping as outlined in the narrative of this report. There is a need for agencies to have robust record keeping and management systems in place and to make enquiries where there are information gaps. In Megan's case, the nursery and school did not have any GP Practice details, background history of Megan and her family dynamics.

7. Learning from SCRs

All safeguarding agencies must remind staff of the requirement to make themselves aware and to comply with the learning from previous SCRs. The NSPCC on their website every year, publishes recent learning from SCRs which highlights similar learning relevant to the 2017 and this review and action to be taken to inform professional practice.

8. Professional Curiosity and Optimism

There was a consistent lack of professional curiosity and scrutiny displayed in the assessment of child protection concerns for Megan. There were missed opportunities for supervisors and practitioners' professionalism to consider and capture the wider picture of possible neglect concerns which were evident. There was too much optimism shown by the SW and IRO when conducting the SGO application of PGM's capability to care for Megan

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SCR Megan

In September 2019, the GSCB Independent Chair (IC) made the decision there was a need to reassess the 2017 SCIE SCR for Megan to consider the original findings and

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any legislative and guidance changes since the conclusion of the criminal proceedings. This SCR was commissioned and has further analysed effective changes to professional practice in the interim period.

Megan was aged two years when she was placed with her PGM in 2012 under an SGO. A DNA test identified C was her biological father - the son of the PGM. Both were unaware of Megan previously. An SGO assessment recommending the PGM was made to the Family Court Proceedings which this review found to be flawed and rushed due to apparent time constraints. The report did not sufficiently consider concerns expressed during the application process. This was a failing of professional practice and not in the 'best interests' of the child.

When she attended nursery and school, signs and symptoms of neglect were present which were not effectively explored by practitioners. There was no effective communication and sharing of information between agencies. These were missed opportunities and a failure to share potential safeguarding concerns with other professionals, notably to and from GCSC (which did not occur) who were fully aware of Megan's vulnerabilities, her background that she was a previous LAC and had been a subject of a CPP for likely neglect by her mother, Amanda. Concerns permeated from the Nursery, Family Support Officer, Children Centre, Health Visitor, her school and the Designated Safeguarding Lead with no joined up working or exploration of Megan's lifestyle with PGM or the fact PGM did not bother registering Megan with any GP Practice. Calling a professionals meeting or holding a strategy discussion may have determined and captured previous concerns and was not considered.

In June 2015, 6-year-old Megan was taken to hospital. She described as "acutely unwell" underweight and had sustained significant bruising over her body considered as Non-Accidental Injuries. She was very thin and small for her age and dehydrated.

The injuries were considered non-accidental and Megan was removed from her PGM's care and placed into a foster care placement Megan disclosed significant and persistent cruelty and abuse, against her PGM, Birth Father C and PGM's partner and her Paternal Aunt (PA). Due to her disclosure (see Megan's story below) they were all subsequently arrested and convicted at court for offences against Megan of Assault, ill-treat, neglect, abandon, a child or young person, to cause unnecessary suffering or injury, which occurred throughout her placement with her PGM from 2012 until 2015.

PGM (7 years), her partner (2 years) and Megan's father (3 and half years) were found guilty and received substantial custodial sentences. The PA was found not guilty during the course of the trial.

Megan is now in a long-term foster placement and is thriving. The cruelty and abuse she endured was as a result of failings of professional practice and assessments which the findings and recommendations from SCIE SCR 2017 and findings and the recommendation in this SCR for Megan have been incorporated into the GCC Action Plan which is being implemented to address and protect children and young people for the future.

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'Megan's voice has to be heard, as her home life in the PGM's home can only be described as a Dickensian lifestyle that should not and will not be accepted in society today. Her story is a lesson as to what can happen when processes are not up to an acceptable professional standard.'

Megan's story describes her horrendous life whilst a subject of the SGO living with her PGM. PGM "smacked her bottom, back and tummy and made her feel sad and did not know why'. 'Daddy smacks her and hits her with a wet tea towel and his hands' which happened every day. She would feel sad and cry. Granny would say "shut up".

Megan did not get cuddles from PGM or her father as 'they did not like her," She was not allowed to watch TV, not allowed in the living room and would get a smack if she went into the room. She had to eat alone downstairs and after tea she would have to go upstairs and hold a heavy Lego box above her head. When she was in bed, PGM would not allow her door to be left open making her feel sad and frightened. People were not kind to her, no one loved her, no one put her to bed, she had to dress and look after herself.

She was hung up on a door and when she fell off, she was put back up and this made her feel sad. Both the PGM and her partner made her eat "dog poo and threatened to chop her fingers off." She was put in a suitcase and was threatened to be pushed down the stairs and even disclosed her PGM wanted to drown her in the bath.

One neighbour provided a statement and said she has seen the PGM grab Megan's hands and then smacked Megan's with her own hands into her face. She described the PGM as being really spiteful. She also witnessed the PGM and Megan in the back garden where the PGM was feeding Megan and the dog off of the same spoon.

There was a disclosure of child sexual abuse although there was no physical evidence on examination. Expert opinion could not rule out CSA. It was however, not proceeded with after the advice was obtained by the Crown Prosecution Service.

The mental and physical stress Megan was going through was immense for any person of any age let alone for a young child aged between two/three and six years. The evidence is the abuse had been occurring for 3 years. She was alone, frightened and why the abuse was occurring, she did not know, starved of human warmth and care. The obvious sign of neglects in her educational setting were not fully explore, her voice was never heard and acted upon. It was known on school and nursery records there was no GP Practice recorded yet this was not followed up as PGM had not registered Megan with a GP Practice. There had been no communication with her previous GP when she was a LAC. There was a lack of professional curiosity and Megan was failed.

There was no one realistically protecting her, she was alone in her abusive life and is a travesty which must not happen again.

SCR Recommendation 1 above, overarches previous learning to address concerns that could still manifest themselves if changes are not made. It applies another level of safeguarding, not to go direct to an SGO and requires the Local Authority to develop a

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clear pathway to ensure applicants for an SGO are properly assessed by holding a Family Group Conference and to ensure safeguarding by applying for an interim Kinship foster placement in the first place which has no timescales, it has supervision, support groups, home visits and training which foster carers must comply with, which does not apply when a child is under an SGO. An SGO gives parental responsibility and

there is no statutory requirement to comply with such support or interventions. The recommendation will remove the presumption a case would become an SGO in any case at court. The intended family member would be subject to a thorough and tested assessment to ensure the long-term welfare and future is for the best interest of the child. If the applicant's assessment is successful only then will an SGO be applied for and supported by a positive and not an optimistic report, as was the case for Megan, recommending the applicant to the court.

Gloucestershire CC has implemented and is implementing, positive changes as a result of the 2017 and this SCR review, together with local and national learning from previously published serious case reviews. Professionals within Gloucestershire are adamant lessons must be learnt.

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