Gloucestershire Safeguarding Children Board

SERIOUS CASE REVIEW

for

THE CHILDREN of FAMILY Y

OVERVIEW REPORT

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A GLOUCESTERSHIRE SAFEGUARDING CHILDREN BOARD COMMISSION

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Chapter 1 – Overview Report

Executive Summary

Introduction

1.1 This Serious Case Review was commissioned by Gloucestershire Safeguarding Children Board (GSCB) in respect of four children referred to as 'The Children of Family Y.' A decision was made by the LSCB to anonymise the report and remove all geographical references, to ensure the family cannot be identified due to the nature and vulnerability of the children and the fact that they are all at various stages of therapy and other support as a result of their experiences.

1.2 The four children had been known to Children's Social Care (CSC) since 2008. They were all victims who suffered from significant and chronic neglect over many years.

1.3 It transpired that the eldest sibling (male) committed intra-familial Child Sexual Abuse (CSA) on his three younger siblings (one female and two males) on numerous occasions over a period of time from 2012 to 2016. He subsequently pleaded guilty to all the offences charged against him at Court.

1.4 Mother and Father, the parents of the four children were estranged and had not been in a relationship for many years prior to the disclosure of CSA. Mother has other children by another relationship who are half-siblings to the four children. After the police investigation, both parents were subsequently charged with neglect offences committed against the children and pleaded guilty to the charges at Court.

1.5 The case was considered by the LSCB SCR Sub-Group. As a result, the Independent LSCB Chair made the decision on the 11th December 2017 that the criteria were met to commission the SCR. The criteria is in accordance with s5(2)(a) and (b)(i) LSCB Regulations 2006[1] and Working Together to Safeguard Children 2015[2]: -

- '*Abuse or neglect of a child or young person is known or suspected* and
- *the child or young person has died or 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 or young person*.'

Background

1.6 The family, consisting of three male children and one female child who were all victims of serious neglect over many years. The eldest male is both a victim of this neglect and also the perpetrator of intra-familial child sexual abuse. Professionals for many years failed to take effective action and there were missed opportunities to ensure they were appropriately safeguarded and protected.

1.7 A chronology of the key events and professional practice was analysed within the review. These show the contact with agencies and practitioners and the concerns raised of extremely poor conditions of the home and serious neglect issues. Mother consistently

[1] 2006 Section 5 (2) (a) and (b) (i) Local Safeguarding Children Board Regulations
[2] Working Together to Safeguard Children, 2015, Guidance - HM Government March 2015.

failed to provide care and support for the children; even with agencies providing family support.

1.8 The local CSC record a number of referrals and contacts. Each referral resulted in an initial assessment (IA) at the time being completed but no intervention offered to the family by CSC. The concerns that led to these referrals focused on neglect and very poor home conditions. When the social worker (SW) visited the home, Mother made reassuring statements about improving the home situation. The children were initially seen to be in good health although living in a poor environment but, there was no evidence in the assessments, of hearing the children's voice or of them having been spoken to by professionals.

1.9 The children were placed on a Child Protection Plan (CPP) on two occasions under the category of neglect. The first CPP was closed despite the circumstances of the home conditions and the neglect of the children still being present. There appears to have been an over optimistic approach by professionals that Mother would improve and sustain improvements which, she never did on any occasion.

1.10 Two of the children attending School 1 were reported to be soiling themselves on a daily basis and both had persistent headlice. The female child was referred to an incontinence team, but she was not brought (WNB) to the appointments by her Mother.

1.11 Mother was also informed on several occasions to make appointments with the family GP for this child regarding her encopresis (soiling) and with her dentist, as she had severe dental decay. Mother said she had contacted the GP and both she and her daughter were given medication. The Social Worker (SW) followed up with the GP to see if Mother had complied with the advice and found she had not seen the GP. Mother was displaying disguised compliance traits and was often untruthful to professionals.

1.12 Soiling is a possible sign and symptom of CSA which professionals did not recognise or consider in their interaction and assessments with the children. There was no professional curiosity displayed and assessments were lacking in quality and depth. It is evident the voice of the four children were not effectively obtained to understand their perspective of life.

1.13 Comments made by court officials when the eldest sibling later appeared at the Crown Court to answer to his criminal charges were, the home environment conditions were filthy and the children often went hungry, there was little or no supervision by any grown-up, including their elder adult half- siblings, with no boundaries or rules put in place. The children were being left to look after themselves and even had to put themselves to bed. The Court heard the lack of rules at home and the general neglect the accused had suffered, were principal reasons he behaved as he did, to abuse his younger siblings. It was accepted he had a very difficult childhood which, all four children had suffered.

Court Proceedings and Outcome

The elder sibling

1.14 He was charged with several counts of rape and causing a child to engage in sexual activity that he committed against his siblings between 2012 and 2016. He pleaded guilty to all the charges made against him. He was subsequently sentenced at Court. To ensure his identity is protected, the full details of his sentence has been redacted.

Mother.

1.15 In court, Mother was described as totally neglecting of her four children, who were left to fend for themselves in a 'filthy and squalid' family home. The children lived without boundaries or rules and did not know the difference between right and wrong. She failed to provide even the most basic things and 'very much' seriously neglected them.

1.16 Mother was charged with several counts of neglect against her children from 2008 until 2016. She pleaded guilty to the offences charged against her and was sentenced to a term of imprisonment. The full details of her sentence has been redacted to preserve anonymity.

Father.

1.17 The court heard, he rarely visited the home and when he did, he was pretty cross and 'nasty.' He pleaded guilty to one count of neglect from 2008 until 2011 against the eldest child only, which was accepted by the court. He received a suspended prison sentence, again the full details of his court sentence has been redacted.

Half-Sibling 1.

1.18 It was believed Mother and the elder half-sister knew about the sexual abuse by the eldest child taking place in the family home. Police conducted a sexual abuse investigation and a decision was made that no charges would be preferred against her.

Further disclosures by the younger sister.

1.19 The younger sister, in 2018, after the terms of reference (TOR) period of this SCR, made further disclosures of sexual abuse by her elder brother on her. This was not proceeded with after advice was obtained from the Crown Prosecution Service (CPS) as there had already been a been a conviction at Court and a decision was made that no further charges against him would be preferred.

1.20 The younger sister also alleged her elder half-brother sexually abused her elder brother. The half-brother was arrested by police and denied any offence. The elder brother was spoken to by police about the allegation but did not make any disclosures. No Further Action (NFA) was taken.

Purpose of the review

1.26 The purpose of this SCR is to: -

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children and young people.
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and,
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children and young people.

Periods of concern and key areas of consideration

1.27 There are five periods of concern identified for the children for consideration. These concerns are detailed within Chapter 3, Analysis of Key Events and Analysis of Professional Practice. The periods of concern are: -

Period 1 - History and background of family.
Period 2 - TOR scoping period commencement. CP concerns and action taken.
Period 3 - The Children of Family Y disclosure of CSA.
Period 4 - Police Criminal Investigation and outcome for children.

Findings

1.28 The serious case review identified the following findings which are expanded upon within Chapter 3, Key Events and Chapter 4, Professional Practice and within the Findings and LSCB Overview Report and Individual Agency Recommendations in Chapter 5 and 7. The findings are: -

Finding 1 - Governance and Supervision
Finding 2 - Signs and symptoms of Child Sexual Abuse and Child Neglect
Finding 3 - Referrals, Risk assessments and sharing information
Finding 4 - Multi-Agency Child Safeguarding chronologies
Finding 5 - Record Management
Finding 6 - Child focused and hearing the Voice of the child.
Finding 7 - Learning from SCRs**.**
Finding 8 - Was Not Brought (WNB)
Finding 9 - Police Protection
Finding 10 - Child Medical Examinations
Finding 11 - Legal Proceedings
Finding 12 - Professional curiosity, optimism and disguised compliance

Conclusion

1.29 It took a significant event of the disclosure of CSA before the children were finally protected from their ongoing neglect, health concerns and poor home conditions which professionals were focusing on. Professionals in their interaction with the children did not consider whether their presentation were possible signs and symptoms of CSA.

Chapter 2 – Initiation of the Serious Case Review

Terms of Reference (summarised)

2.1 The review process was conducted in line with the principles for SCR's set out in Working Together to Safeguard Children 2015[3] and aims to contribute to learning and improvement through consolidating good practice and identifying where practice can be improved. The principles, set out in the statutory guidance, are: -

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;

[3] Working together to safeguard children 2015, Guidance - HM Government March 2015.

- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;
- The review will recognise the complexity of safeguarding children and seek to understand not only what happened but why individuals and organisations acted as they did.

Agency involvement

2.2 The following agencies were involved in the SCR process and completed Individual Management Reports (IMR) or a summary of their agency involvement: -

- **Local Authority Children's Social Care** - IMR completed.
- **Local Authority Care Services** - IMR completed.
- **Local Authority Hospitals NHS Foundation** - IMR completed.
- **Local Authority NHS Foundation Trust** - IMR completed.
- **Schools 1 and 2 (Redacted)** - IMR completed.
- **Local Clinical Commissioning Group (CCG)-** IMR completed.
- **Local Authority Police -** IMR completed.
- **Youth Support Services** - Summary provided.
- **Local Authority Housing Department** - Summary provided.
- **Ambulance Service**- Summary provided.
- **Youth Offending Team -** Summary provided.

Scope of the review

2.3 The review covers the period from 4th October 2012 (a joint home visit (HmV) between police and CSC) until Interim Care Orders (ICO) were obtained for the children in 2017.

General Terms of Reference for Review

1.1	To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard children and young people and promote their welfare
1.2	To consider whether there are any specific cultural issues within one agency that may have affected decisions made by another agency
1.3	To review the effectiveness of procedures (both multi-agency and those of individual organisations) and understand what is present in our safeguarding system to enhance or hinder good practice.
1.4	To inform and improve local inter-agency practice.
1.5	To improve practice by acting on learning (developing best practice).

1.6	To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

Specific Terms of Reference for Review

1.7	To examine the quality of risk assessment and understanding of the Levels of Intervention guidance.
1.8	To consider how and when the child's views and experiences were considered and taken into account in the decision-making process.
1.9	To examine the level and quality of partnership working.
1.10	To consider whether recommendations from previous reviews involving chronic neglect have been implemented and whether there is any evidence of a change in working practices.
1.11	To consider whether professional differences occurred, and if so, how they were responded to**.**
1.12	To consider all agencies understanding of when information can and is shared.
1.13	To examine professional understanding of the signs and indicators of CSA.
1.14	To consider how information known about the older siblings to this group of children (not within the scope of the review) and their lived experiences as children was used to inform risk assessments and planning.

Family Composition and Children subject to the review

Subjects of SCR	**Date of Birth (Redacted)**
Male	Eldest – Perpetrator of CSA and Victim of Neglect.
Female	Victim
Male	Victim
Male	Youngest - Victim

Family Members

- **Mother**
- **Father** (estranged and not in a relationship with Mother)
- **3 elder half siblings**
- **Paternal Grandfather**
- **Paternal Aunt**

Independent Overview Author

2.4 Independent Overview Author (IOA and Lead Reviewer), David Byford, was appointed to carry out the SCR and has met all deadlines set by the LSCB.

Methodology

2.5 The LSCB agreed a mixed methodology to understand professional practice contextually, to identify factors which influenced agencies and professionals in their decisions taken and, the nature and quality of work with the family. The IOA identified through the initial agency submissions and again after a practitioner's event, that further information was required. This additional information was provided within the agency final submissions.

2.6 In carrying out this review the following approaches were made: -

- A research and review of local and national safeguarding policies and procedures, care plans, CIN review meetings and consideration of previous LSCB SCR's, previous Ofsted Inspections together with additional research of guidance material.
- Analysis of agency SCR submissions to ensure compliance with the TOR and statutory requirements.
- A Practitioners Event was held.

Publication

2.7 The intention of the Local Safeguarding Board is to publish locally a highly anonymised version of the report. In the future a copy of the full report with all geographical reference removed to preserve the identity of the family and children concerned will be lodged with the NSPCC to ensure that the learning can be shared. The reasons for this approach is to protect the identity of the children who are all being supported to overcome the impact of these events and it will take some time for these interventions to be successful.

Chapter 3 - Analysis of Key Events

3.1 The key events together with the input from the agencies and practitioners participating in this review, are further analysed within this section. It has been summarised and outlines the key events to show how the concerns over the five periods of identified concern developed, together with the professional action taken.

DATE/YEAR	KEY EVENTS - PERIOD OF CONCERN
History and background of family	**Period 1**
<u>October 2008</u> **Initial police referral to CSC. Issues are: -** • **Concern of poor home conditions.** • **Neglect of children.** **First Initial assessment (IA) undertaken. CSC closed the case with NFA. Mother declined a CAF.**	Police made a referral having attended the family home following the arrest of an elder half sibling in relation to a burglary. They were appalled at the living conditions, describing as filthy, untidy, with animal mess and food on the floor. The bedrooms were in a poor state with worn mattresses, and mouldy blackened windows. There was no food in the kitchen cupboards. It was suspected by police; the elder half sibling may have committed the crime due to survivalist reasons (a term suggesting the need to feed and care for himself) but this comment was not expanded upon. The Local Authority CSC completed an IA. There was no intervention offered to the family by CSC. The children were seen to be in good health, but there is no evidence in the assessments the children were spoken to about their lives. Mother felt that she will manage to put things straight and would not need a Common

	Assessment Framework (CAF). No Further Action (NFA) was taken.
2009	Concerns were made by neighbours, stating one child was looking withdrawn pale and neglected and one who was quite young looked tired with bags under her eyes. It was alleged the family were living in squalor. CSC record NFA.
February 2010 **Initial assessment (2)**	CSC received an anonymous referral stating the house was disgusting and the children are very dirty, had head lice and sores, also new baby in the house. IA and recorded as NFA. Health Visitor (HV) telephoned CSC stating the house was in need of decoration but was not dirty or unsanitary in anyway. The second youngest male sibling was being cared for well. No further rationale recorded. NFA.
September 2010 **Initial Assessment (3)**	CSC received an anonymous call received concerning the state of the children. The girl had 'disgusting hair with head lice,' the house was described as a mess and not liveable. Outcome: An IA completed. Case was not felt to meet the threshold for services, a final home visit (HmV) was made and referral sent to a children's centre to work with family. NFA and case closed 29/11/2010. **Comment: The assessment did not take into account the pattern of referrals indicating that the children were often dirty, and the home conditions were unacceptable and to a poor standard.** Later in the month CSC received a further anonymous referral regarding neglect. Advice given to family and case closed, NFA.
December 2010 **Initial assessment (4)**	CSC obtain information regarding home conditions and concerns for one of the children with a HmV requested under section 17. Outcome- IA completed case closed, NFA.
February 2011 **Initial assessment (5)**	Concerns regarding one of the children's teeth and personal hygiene. An IA was completed and a School Nurse (SN) engaged. The case was again closed to CSC and NFA taken.

Analysis of background period

There were five IA's carried out during this first period which were all subject to NFA being taken. There was no professional curiosity or supervision oversight evident. The continuing concerns of serious neglect, persistent health issues and extremely uninhabitable home conditions persisted which, the children were expected to live in.

There was too much practitioner optimism allowed of Mother who agreed to improve the home environment and the health and neglect issues of the children. No improvements ever occurred, and the account of Mother (who was displaying disguised compliance), showed she could not or would not provide care and support to her children. Father of the children was not present in the family home but had contact. It was believed he was aware of his children's neglect and the worrying health issues yet, did not attempt to relieve their suffering and provide the necessary care and support for them.

There were numerous missed opportunities to safeguard the children and is a failure by agencies. There should have been an Initial Child Protection Conference, (ICPC) held with the evidence available on numerous occasions. Police had an opportunity to use their powers of

police protection but did not do so however, they followed up their concerns about the home conditions and appropriately referred the case to CSC. No practitioner ever considered invoking escalation policies as the children were left in such neglectful conditions and is a finding in this review for learning.

In conclusion, this period reported health concerns on four occasions, as alluded to above, there were five IA's with seven occasions when CSC took NFA and closed the case, (seven reported neglect concerns and five reported concerns of the unhealthy environment of the family home). It is clear these concerns remained and never improved throughout this period despite professionals working with the Mother. The voice of the child was never effectively heard.

TOR scoping period commencement. CP concerns and action taken	**Period 2**
2012 and 2013	**Analysis of events in 2012 and 2013** (*Information obtained from the female child's 2017 disclosure to Police states it was around, September 2012 when she said the CSA commenced as admitted to by her elder brother subsequently at Court. It is placed in chronological order to show the start of events occurring in the family during the time of professional involvement).* During this timescale the focus remained on the home environment and not on the children. Neglect issues for the children still persisted. In October 2012 a core assessment first notified practitioners of her regular soiling. An ICPC was held and the children were placed on a CPP for neglect. At the first RCPC the children were removed from the CPP which is considered premature as the soiling and the poor home environment still existed. Initial work was held to capture the voice of the children but from December 2012 to March 2013, no further work was carried out with children. Mother declined support from MH services for herself with no consideration of the impact this decision may have had on her parenting of the children.
2014	**Analysis of events in 2014** The female child's incontinence continued on a daily basis at school and both she and her younger brother had persistent headlice. Throughout, Mother never took appropriate action to address these concerns including taking her to her dentist for her severe dental decay. Mid-term the female child had an initial assessment with a psychiatrist who records the condition could be a sign of abuse which, was not followed up or shared**.** There were two CIN meetings held until September when the CIN process was closed. This was a wrong decision as concerns still prevailed with over optimism of Mother's ability to make improvements to care for her children which she had never managed previously. A new SW Manager was appointed and in the following two months, home visits still observed poor home conditions which the children were

	being expected by professionals to live in with NFA taken.
2015	**Analysis of events in 2015** As in the preceding periods, the same concerns continued without being resolved with no improvement of the home conditions; the worrying concern of neglect and health issues for the children were still apparent. Mother failed to focus on the welfare of the children. There was no consideration to utilise police powers of protection at a home visit where police described the home was poor and inhabitable. They however referred to CSC who conducted a followed up at the family home and as a result further CIN meetings recommenced which were not effective. School 1 were escalating concern to CSC regarding the two children who were soiling themselves on a daily basis and the female child's tooth decay remained outstanding. She WNB to appointments as agreed by Mother who was displaying disguised compliance. This child was also beginning to have behaviour issues at school towards other pupils. Concern with the previous history of the PGF was addressed by professionals as he posed a possible risk to children. Work by an FSW commenced with the family who reported in December further decline in the home conditions. The Children of Family Y were all made subject to a second ICPC and were placed on a CPP for neglect and continued on the plan at a RCPC. There was a lack of urgency for the children and a three-month delay in actioning legal planning. The family's case should have been brought to the attention of the Head of Service earlier in order for scrutiny and oversight of safeguarding action being taken and is subject to the Findings and LSCB OV Report Recommendations in Chapter 4.
Up to June 2016	**Analysis of events in 2016 until Period 3** Environmental health visited the property and reported there was a little improvement. A GP referred the female child for additional support and a Care Coordinator (CC) was allocated for Cognitive Behaviour Therapy (CBT). She WNB for five dental appointments and the dentist refused to offer any more. During a SW home visit in March, Mother was challenged about this and offered excuses. A second RCPC made a decision for the children to remain on the CPP for neglect. Legal proceedings were to commence for neglect of medical, mental health and environment as there was no sustained change. This was an appropriate decision but was allowed to drift with missed opportunities to take action much earlier. School 1 reported the sister stole her brother's toast money as she was hungry as she did not have breakfast in the mornings. School records do not show any action taken regarding this possible neglect issue. The FSW reported Mother, from April was struggling. Mother did not turn up at court for a fraud offence and a warrant was issued for her arrest, but due to the fact she was the sole carer for the children NFA was taken on the failure to

	appear. The sister WNB to a CBT therapy session but this was followed up and she was later taken in May 2016**.** She reported a good relationship with her family although had difficulty with her elder brother. She described difficulty in sleeping and often woke in the middle of the night, often due to needing the toilet and at other times due to having nightmares. The CC was attempting to ascertain if there were any underlying causes such as CSA. It was a missed opportunity to consider the concerns further with other professionals. Mother later took a drug overdose. The hospital clinicians offered Mother support by the Mental Health Liaison Team (MHLT) but this was not taken up by her and again the outcome was not assessed of the likely impact upon her children. A core group meeting later confirmed there was no improvement with the home.
The Children of Family Y - Disclosure of CSA.	**Period 3**
<u>18/05/2016</u> **First allegation of CSA made by the youngest sibling against his elder sibling.**	When the FSW was at the family home, one of the younger brothers made the first allegation of CSA against his eldest sibling. The FSW informed the SW who made the decision to visit the younger brother at school the following day when he again confirmed the disclosure. The disclosure should have prompted an immediate referral and SD with Police as there is a clear disclosure of a criminal offence being alleged and the potential safety of the children in the family home. There was no risk assessment of the concern regarding a half Sibling response to the disclosure. She was reported to have shouted and grabbed him by the head, to stop him from being able to talk to the FSW.
<u>23/05/2016</u> **Criminal investigation and care proceedings commenced.**	A SD was held due to the disclosure. The child disclosed sexual acts of abuse which happened in his elder brother's room. Mother apparently witnessed and shouted at him. Furthermore, care pre-proceedings started. Mother was reported to be facing eviction for non-payment of rent. Police instigated a criminal investigation into the CSA disclosure. All three sibling were subsequently interviewed by police and disclosed sexual abuse by the elder brother against them. He was moved to live with Father.
<u>May/June 2016</u>	A parenting assessment was completed for the unsafe and unhygienic home conditions. It was observed that one of the younger males displayed sexualised behaviour. The response from Mother and an older half-sibling suggested this behaviour was not unusual practice in the home.
<u>June 2016</u> **The eldest sibling was ABE interviewed as a suspect.**	Initial Family Court pre-proceedings took place and during this period Police conduct an ABE interviewed with eldest male. He claimed the allegations were all made up and these three younger siblings were just trying to get him into trouble.
<u>September 2016</u> **RCPC held and the family**	RCPC held and a decision was made for the children to remain on the CPP for Neglect. Mother had not attended any core groups

evicted from their home.	with no sustained change in conditions noted. The review LPM was held and the decision taken to issue care proceedings. Mother requested the children be placed in care due to being homeless as the family were being evicted on the 27/09/2016. Mother said she did not think she could do the best for her children and that they should go into foster care. School 1 report throughout this month report one child was still presenting in a dirty condition and the young girl was persistently soiling herself with both having headlice. She had behavioural issues with other children. The family were evicted and went to live with the MGF. The eldest boy remained with his Father after the CSA disclosure. The MGF thought a Family Group Conference (FGC) would be a good thing but never occurred.
<u>November</u> **Mother requested children to be placed into voluntary care for a second time.**	Mother again requested for her children to be taken into care under Section 20. Three were moved to foster placements. Two were placed together. School 1 report they were concerned regarding the girl's swearing and threatening to harm others school pupils. (no outcome is known). CSC chase up Legal Services as the Court paperwork was not being progressed. The three are voluntary accommodated under a Section 20 agreement given by Mother. All three children were placed with foster carers with two residing together. Later the foster carer for the girl child reported an increase in her soiling and it was too much to manage and gave notice. It was felt she needed a sole carer for her condition.
<u>December 2016</u> **Safeguarding concerns as eldest sibling staying with his PA with younger children in the home.**	A Paternal Aunt (PA) disclosed eldest boy has been staying at her home in her son's bedroom instead of the MGF. This had not been known before and raises concerns about the risk to her child. **Comment: This was a failure by practitioners to carry out an effective risk assessment.** The young girl was later moved in this month, to a separate placement due to her complex soiling needs. At this new placement she later alleged CSA by her elder brother.
<u>14/01/2017</u> **The second youngest male sibling alleged his elder sibling sexually abused him.**	At a SD, information from a foster carer was the second youngest disclosed he had seen the older brother since being in care at the MGF home previously. There was further discussion and that child made a disclosure regarding sexual activity of his older brother and of him acting inappropriately towards him later confirmed in an ABE interview with Police. He was ABE interviewed by police later this month.
Police Criminal Investigation and outcome for subjects	**Period 4**
<u>January 2017</u>	The older child was arrested for serious sexual offences against his

	siblings. Mother was arrested for child neglect and perverting the course of justice, as one child disclosed, she was aware of what the older child was doing to him. Father was later arrested for Neglect.
February 2017 **ICO was granted in Family Court for the three younger siblings**	Care proceedings were held. The Judge granted ICOs for the three younger siblings. He would not grant an ICO for the elder boy as he was with his MGF who would not pass assessment. The Judge gave the local authority until 08/03/2017 to find a placement.
March 2017 **An ICO was granted in the Family Court for Eldest sibling.**	A placement was found for the elder boy and an ICO granted. He was moved to the placement on this day. The three youngest siblings remained with their current foster placements with the eldest boy in a separate foster placement. Mother in court, agreed to the actions taken. She admitted to the neglect of the children, failing to meet appointments and did not raise her depression as mitigation.

Chapter 4 - Findings and lessons learnt with suggested recommendations for the consideration of LSCB

4.1 This chapter outlines the findings and suggested recommendations identified from the analysis of the key events and professional practice. They are produced for the consideration of the LSCB to reflect and implement any learning from this SCR. The findings have been summarised and the fuller version is available to the Local Authority for promulgating the lessons to be learnt from this SCR. The findings with the recommendations below have been accepted by the Safeguarding Board. The LSCB SCR Overview Report Recommendations overarch, encompass and support Individual Agency Recommendations which are included within the Action Plan that accompanies this review, as follows: -

FINDING 1 – Governance and Supervision

What are the issues and what should be considered? This review has identified concerns as to the function of the governance of CP cases with previous history of concerns, including effective supervision of all child safeguarding meetings and the appropriateness of scrutiny of the decisions made. If Initial Assessments identify similar concern that was previously closed with NFA taken, there should be a consideration to treat the case as high-risk until circumstances confirm to the contrary. This is a safeguard for the child or young person and supports practitioners and the LA in the action and decisions taken. There was no consistent management oversight, particularly in early interaction with professionals working with the family.

LSCB Overview Report Recommendation (1) for Child Protection Safeguarding Partners

It is recommended that all local authority Child Protection Safeguarding Agency Partners review the standards of supervision to ensure all child protection meetings, capture the overall picture of safeguarding concerns, ensuring: -

- **An improvement of supervision, including supervision of supervisors, in single assessments, chairs of safeguarding meetings, including CP Plans and CIN meetings and child protection cases, to ensure the wider picture of a safeguarding case particularly those determined high-risk, are captured and acted upon.**

- **Before closure of a referral, safeguarding risk assessment or meeting, consideration as to the causation of presenting concerns must have considered CSA, Neglect and all other signs and symptoms of abuse before closure, subject to management oversight.**
- **Identifying high-risk cases with historical concerns (regardless of the length of the intervening period) with repeating safeguarding concerns, are scrutinised by senior management and referred to the Head of Service if necessary, whose decision is final.**
- **Escalation policies must be used where there is a disagreement as to process or course of action taken.**

FINDING 2 - Signs and symptoms of Child Sexual Abuse and Child Neglect

What are the issues and what should be considered? There is a need for practitioners to improve their awareness and personal knowledge in being able recognise and identify the signs and symptoms of CSA and neglect. The persistent squalid state of the family home, the presentation of the children at school; the young girl's persistent soiling; her brother's soiling, were all health concerns; the lack of urgency for her to attend her GP due to severe tooth decay; her stealing food at school because she was hungry, the failure by Mother to improve the home environment , are together all signs of neglect. This was a failing by professionals in this SCR, to consider or share the wider concerns for children or young people, a theme in other, SCR's. By utilising the Local Authority Neglect Toolkit will assist practitioner's awareness in capturing the evolving safeguarding concerns much earlier, in order to signpost the most appropriate pathway, service and support required to protect C&YP. The Local Authority LSCB should ensure there is a clear pathway for children and young people.

LSCB Overview Report Recommendation (2) for Child Protection Safeguarding Partners

It is recommended all Child Protection Safeguarding Agency Partners and relevant voluntary organisations within the local authority area, assure the Local Safeguarding Children Board that their staff are aware and compliant with the following safeguarding concerns:

- **All safeguarding partners 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.**
- **Where relevant, staff must utilise the Neglect Toolkit in order for practitioners to identify and capture evolving safeguarding concerns at a much earlier stage, in order to safeguard the welfare of children and young people.**

FINDING 3 – Referrals, risk assessments and sharing information

What are the issues and what should be considered? Generally, there was a distinct lack of credible risk assessments in the SCR. Risk assessments must be carried out with the rationale recorded and supervised. Significantly, the younger brother made an allegation of CSA against the eldest to the FSW at a home visit in May 2016. The FSW did not immediately refer the disclosure or call a strategy meeting with police and GCSC. The disclosure was repeated to the SW at school the following day. The disclosing child was allowed to go home without the necessary protection for him and his siblings put in place. On both occasions no risk assessment was carried out and can be construed as a failure to protect him and his other siblings. These were missed opportunities and from a police perspective, the ability to obtain or preserve best evidence may have been compromised.

A care coordinator dealing with the young girl's soiling condition subsequently considered and asked underlying questions of possible other causes for her toileting issues. Again, this was a missed opportunity to share the professional's views and opinions. Furthermore, a Hospital Trust Clinician identified severe dental decay who did not consider communicating the information as a potential

child protection referral to CSC, as the child was likely to need additional support. Regular communication and information sharing between agencies may have resulted in a different outcome being taken for the removal of the children from the family and the earlier recognition of the signs and symptoms of CSA.

LSCB Overview Report Recommendation (3) for all Child Protection Safeguarding Partners

It is recommended all Child Protection Safeguarding Agency Partners and relevant voluntary organisations within the local authority area, assure the Local Safeguarding Children Board their staff are aware and are compliant with the following requirements:

- **To comply with national and local Safeguarding policies, procedures and guidance in relation to referrals, risk assessments and the requirement to share child protection safeguarding information or possible concerns.**
- **When there is a disclosure of an allegation of a crime which impacts on a child or young person, an immediate referral must be made for a strategy discussion, to consider initiating or planning whether a Section 47 Investigation is required. This is in conjunction with any criminal investigation in order to identify the most appropriate action required to be taken to protect and support a child or young person and to preserve potential evidence.**

FINDING 4 - Multi-Agency Child Protection Safeguarding chronologies

4.1 What are the issues and what should be considered? Multi-Agency chronologies were not completed in this SCR. This is recommended learning from previous serious case reviews that safeguarding chronologies should be completed. There were overwhelming historical and current concerns (during the TOR period under review) of the family, in respect of a poor home environment, continuing health and neglect issues with initial assessments being opened and closed with no further action taken where, the worrying concerns persisted with no improvements noted.

LSCB Overview Report Recommendation (4) for all Child Protection Safeguarding Partners

It is recommended all Child Protection Safeguarding Agency Partners and relevant voluntary organisations within the local authority area, assure the Local Safeguarding Children Board that their staff complete background chronologies on their case files on children and families subject to child protection enquires, in order practitioners have the fullest information available to make informed decisions of the most appropriate action required to be taken.

FINDING 5 - Record Management

What are the issues and what should be considered? Agency IMR's indicated a deficiency in record keeping, with no recorded rationales of action taken or why actions made are not concluded or followed up with outcomes recorded. Some agencies addressed this within the Individual Agency Recommendations. There is a need however, for the Local Authority to ensure all safeguarding partners involved in the SCR, have robust record keeping and management systems in place. Records of minutes of safeguarding meetings should be completed diligently and shared with participating agencies. Some IMR's raised the concern they were not receiving them or when they did it was after some delay.

LSCB Overview Report Recommendation (5) for all Child Protection Safeguarding Partners

It is recommended all Child Protection Safeguarding Agency Partners within the local authority area, assure the Local Safeguarding Children Board of the following requirements:

- **Their recording keeping, and management systems are robust, comprehensive and up to date and,**
- **Minutes of safeguarding minutes are promptly completed and shared with involved safeguarding partners.**

FINDING 6 – Child focused and capturing the voice of the child

What are the issues and what should be considered? Multi-agency meetings and core groups must be child focused and consider all presenting options including a child or young person's health concerns and in the young girl's case, the behaviour displayed at school including her aggressiveness towards others and why she kept a screwdriver under her pillow at night. These are all possible warning signs that something was not right. The persistent soiling were further possible signs and symptom of CSA or that other forms of abuse could be taking place. These issues were not considered and is also discussed in Finding 2 above.

The voice of the children was not captured particularly in the early years of professional interaction both in interaction with practitioners and in initial assessments. "Think children first" is an emphasis on the priority of a child's welfare over parents with professional curiosity and disguised compliance awareness and training. Practitioners were overly optimistic and believed Mother would take her children to health and dental appointments and to clean the family home which was in an intolerable condition. She never complied. There must be proactive engagement with children which appears lacking in this case.

LSCB Overview Report Recommendation (6) for all Child Protection Safeguarding Partners

It is recommended all Child Protection Safeguarding Agency Partners and voluntary organisations within the local authority area, assure the Local Safeguarding Children Board they have reminded their staff of their duty in safeguarding cases to ensure the voice of the child is captured and are focused on the experience and impact on children, as identified in learning from previous serious case reviews.

FINDING 7 – Learning from SCRs

What are the issues and what should be considered? All safeguarding agencies must remind staff of the requirement to make themselves aware and to comply with the learning from previous SCR's. The NSPCC,[4] on their website every year, publishes recent learning from SCR's.

The learning from two recent SCR's contained in the conclusions, highlight the same concerns are replicating themselves in this review. IMR Authors acknowledge this aspect and have addressed the concerns within their SCR IMR submissions and agency recommendations.

LSCB Overview Report Recommendation (7) for all Child Protection Safeguarding Partners

It is recommended all Child Protection Safeguarding Agency Partners and relevant voluntary organisations within the local authority area, assure the Local Safeguarding Children Board they have informed all supervisors and staff of the need for all practitioners to have the required knowledge and awareness of recent learning from previous serious case review publications, in order to ensure their decision making and actions to safeguard children and young people that similar concerns are not being repeated

[4] NSPCC Yearly audit of published SCR'S.

FINDING 8 – Was Not Brought (WNB)

What are the issues and what should be considered? Consensus of opinion of practitioners within the SCR and during the practitioners' event held, consider WNB a more relevant terminology rather than Did Not Attend (DNA). DNA gives an emphasis on a child not attending an appointment, but as in this case, it is the parent or carer who generally does not bring the child or young person to an appointment. It is suggested the Local Authority adopt WNB as policy.

LSCB Overview Report Recommendation (8) for all Child Protection Safeguarding Partners and the Local Authority

It is recommended all Child Protection Safeguarding Agency Partners and relevant voluntary organisations and the local authority, assure the Local Safeguarding Children Board of the following requirements:

- **The local authority adopts the more appropriate terminology of 'Was Not Brought' (WNB) instead of 'Did Not Attend' (DNA) which unjustly places an emphasis on a child when it is the parent or guardian who does not bring a child or young person to an appointment.**
- **All safeguarding partners have suitable policies in place if a child is persistently, WNB to appointments. There must be supervision oversight to consider if this indicates harm to a child and the details recorded within the child's chronology.**

FINDING 9 – Police Protection

What are the issues and what should be considered? The Police IMR identified that police officers could have utilised their powers of police protection on several occasions when the children were found in squalid unhealthy condition within the family home. It was suggested this may be a lack of knowledge by some police officer of their powers and may require additional training. This was not systemic however, as police officers on other occasions did show professional scrutiny and appropriately invoked police protection.
(There is no requirement for a LSCB Overview Report recommendation as this has been addressed by a Police Recommendation).

FINDING 10 – Child Medical Examinations

What are the issues and what should be considered? There was concern raised by Local Authority Care Services when a CSC social worker contacted a Consultant Paediatrician to request medical examinations when, there was a significant period since the last physical contact between the abuser and his younger siblings. There is a need to seek clarity and agree a clear memorandum of understanding between Health, Police and CSC to ensure the correct procedure is taken within the Local Authority.

LSCB Overview Report Recommendation (9) for Local Authority, Children's Social Care, Police Service and Care Services

It is recommended Children's Social Care, the Police Service and Care Services, within the local authority area, assure the Local Safeguarding Children Board there is an agreed memorandum of understanding, in the correct procedures and action to be taken for the completion of children and young people's medical examinations, to ensure clarity of the purpose and achievable objectives.

FINDING 11 – Legal Proceedings

What are the issues and what should be considered? From the time of the decision to the issue of initial care proceedings for the four children, there was some drift. There was also a lack of information on the progress which IMR Authors and attendees at the SCR Practitioners Event commented upon. There is a need that CSC should ensure there is communication with Legal Services in order to obtain regular updates on the progress and where there are delays, these are kept to a minimum and the progress shared to interested parties in the family's legal proceedings.

LSCB Overview Report Recommendation (10) for the Local Authority Children's Social Care and Legal Services.

It is recommended the Local Safeguarding Children Board require the local authority Children's Social Care and Legal Services agree regular communication and updates on the progress of family cases in legal care proceedings. This is in order to keep any delay to a minimum and for interested parties to the proceedings to receive regular information of the progress of the case.

FINDING 12 – Professional curiosity, optimism and disguised compliance

What are the issues and what should be considered? There was a consistent lack of professional curiosity and scrutiny displayed in the assessment of child protection concerns apparent throughout the SCR for the children. There were missed opportunities for supervisors and practitioner's professionalism to consider and capture the wider picture of other possible factors of the abuse and neglect the children were having to live with. Failings which should not be reoccurring as there is clear learning from other SCR's which were replicated within this review. Furthermore, Mother was displaying clear disguised compliance practices. There was too much professional optimism on Mother who always ignored advice and persistently failed to support and protect her children. She openly lied to practitioners about taking her children to appointments. Persistently the children WNB to GP and Dental appointments and she failed to make improvements to address the uninhabitable home which the constant neglect and health concerns the children had to suffer over a long period of time.

LSCB Overview Report Recommendation (11) for all Child Protection Safeguarding Agency Partners

It is recommended all Child Protection Safeguarding Agency Partners and relevant voluntary organisations within the local authority area, assure the Local Safeguarding Children Board that staff have supervision oversight on their child protection safeguarding cases, to ensure there is professional curiosity displayed, and not a propensity to have an over optimistic view of compliance by parents and carers with disguised compliance challenged where displayed.

Individual Agency Recommendations

4.2 The participating agencies to the SCR for the children have identified learning for their respective agencies during the SCR process. Their recommendations have been agreed by Agency Heads of Service and Senior Management and will form part of a LSCB SCR Action Plan that will follow this overview report. They have been agreed by this SCR to be relevant and necessary.

4.3 Specified questions posed in the TOR in Chapter 2 were addressed within IMR's and taken into consideration and subject to the Findings and Recommendations above.

Chapter 5 – CONCLUSIONS

5.1 This SCR Overview Report for the Children of Family Y is LSCB's response to establish future learning to provide explicit child protection safeguarding within the local authority area. Learning has been identified before within national SCR's which have not been taken into consideration as mentioned within the narrative of this report. This SCR re-emphasises and addresses the previous learning supported by the additional findings and recommendations within this review.

Predictability and Preventability

5.2 The circumstances of the serious neglect, escalating health concerns and inhabitable home conditions of the children were identified back in 2008. Despite continual interaction through the following years with CSC, health providers, school and police, there was an over reliance on a Mother who continually displayed disguised compliance, (and Father to a lesser but still a significant extent) to make and sustain improvements to her children's life which she failed to do, even when support was provided and offered.

5.3 The Analysis of Key Events and Professional Practice outline the continual and repetitive child protection concerns. It was not until late in December 2016 when the intra-familial CSA disclosure against the eldest sibling came to notice, when appropriate action was taken to protect them.

5.4 More worryingly, the signs being displayed by the children in particular the young girl, were clear signs and symptoms of CSA. CSA was not considered by practitioners and we know in hindsight, the perpetrator started to sexually abuse his siblings from 2012 until May 2016.

5.5 In conclusion the neglect, health concerns, poor home conditions and missed CSA (from 2012) should have been both predictable and preventable with the amount of contact and interaction with professionals from 2008 until the disclosure (neglect continued after the CSA disclosure until 2017) when the children were all placed in foster care.

Opportunities to intervene prior to abuse

5.6 There were numerous missed opportunities to take safeguarding action throughout agency involvement with the family, as outlined in the analysis of Key Events in Chapter 3 and within the Findings in Chapter 4. LSCB OV Report and Individual Agency Recommendations will hopefully address the concerns for robust safeguarding action to be taken in future child protection cases.

Engagement with professionals - Practitioners Event

5.7 A Practitioners Event was held that was well received and attended by agency practitioners involved in the SCR. It was hosted by the LSCB, LSCB Business manager, the SCR Chair and the Lead Reviewer. The issues submitted for discussion was elicited from the analysis of agency submissions. Practitioner's views were taken into consideration and identified further analysis and where relevant to the review are subject to the Findings and LSCB OV Report Recommendations in Chapter 4 and within the Individual Agency Recommendations which form part of an Action Plan accompanying this SCR.

Voice of Mother, Father and elder half-siblings

5.8 Mother, Father and Sibling 1 were offered the opportunity to participate in the review but the LSCB received no response. Therefore, their views cannot be incorporated and questions as to the care and support provided to the children have not been obtained. Advice from CSC not to communicate for purposes of the review with any of the siblings was accepted and complied with.

Local and National Safeguarding Policies and Procedures

5.9 A vital element identified in this SCR was the requirement for practitioners to have the knowledge and awareness of local and national Safeguarding Policy and Procedures. There is a need to ensure compliance and now the requirement to utilise the local authority Neglect Toolkit and to recognise and act upon the signs and symptoms of CSA.

Culture and Diversity

5.10 Culture and diversity was not an identified issue within this SCR.

Previous SCR's

5.11 **SCR 1 (Redacted) -** This was a case where the children fostered were seriously neglected by the foster carer. Recommendations within the SCR resonate with this case in that the chronologies and interventions of partner agencies should be shared. This did not consistently happen in this review. A further recommendation was regarding multiple medical needs and for health professionals to co-ordinate and follow up the medical appointments. In this case there were numerous failures of WNB to attend GP appointments, continence and dental appointments for treatment.

5.12 **SCR 2 (Redacted) -** There are many similarities with the four children's experience, including being part of a large family who were neglected over many years. There were numerous indicators of neglect which are consistent with this case, including tooth decay, severe and persistent head lice, missed health appointments and poor hygiene. Parents and carers making small changes were not sustained as was the case with Mother in this review, bringing the focus back to her own needs with excuses and failures to build a relationship with her children and failing to understand their needs from their perspective.

5.13 There was extensive work undertaken within social work teams to share the learning and recommendations from previous SCR's. The key themes and which are also findings in this SCR were: -

- Listening to children and seeing the child's world.
- Levels of need and the limitations of an incident led approach to child neglect.
- The impact of professionals feeling overwhelmed or desensitised, and the challenge of working with parents who are manipulative or show disguised compliance.
- Professionals not feeling valued and listened to, and the lack of a culture of resolving professional disagreements.
- Understanding neglect.

Comment: There was no evidence in any case notes or meeting minutes that professionals reflected on the recommendations from previous SCR's as it applied to these four children. Neglect was allowed to continue, and it took an incident and disclosure of CSA for professionals to act more decisively. Learning from previous SCR's must be considered and

acted upon if similar concerns are evident and repeating themselves. It is the professional's own responsibility to ensure this is done. The failure to learn from SCR's was an element of the Alan Wood's review (2017) into LSCB's.

Professionals Overriding Responsibility

5.14 As stated within Working Together to Safeguard Children 2015,[5] professionals working within CP must ensure compliance with the following doctrine: -

Local Authorities have overarching responsibility for safeguarding and promoting the welfare of all children and young people in their area. They have a number of statutory functions which make this clear[6], and this guidance sets these out in detail. This includes specific duties in relation to children in need and children suffering, or likely to suffer, significant harm, regardless of where they are found, under s17 and s47 of the Children Act 1989.

Comment: It is clear that standards of child protection fell short of this expectation. The fundamental responsibility for safeguarding and promoting the welfare of all children and young people was not consistently followed which, the agencies and professionals who participated in the SCR have addressed for learning. (See Findings and LSCB OV Report in Chapter 4).

Professionals must ask themselves. Would I live or leave my children in circumstances these four children faced on a day to day basis, suffering neglect, worrying health concerns and living in an appalling uninhabitable family home? From the information this SCR has obtained, the answer must be a categoric 'no.' This SCR hopes to ensure this does not happen again if lessons from this review and other SCR's are complied with in the future by professionals and effective management oversight ensures compliance.

If the disclosure of child sexual abuse had not been made, the likelihood is, these children would have continued to have a neglectful life, living in a poor home environment, harmful to their health.

Overview Report submission to the LSCB

5.15 This serious case review is submitted to the Local Safeguarding Children's Board for their information and consideration of promulgating the lessons to be learnt from the suggested enclosed findings and recommendations.

[5] Working Together to Safeguard Children 2015 - HM Government March 2015
[6] Children Act 1989 and 2004.