Safeguarding Children Board

Serious Case Review C67 and C68

Incident: 22nd January 2018.

Author: Paul Northcott

Date review report completed – 4th March 2020.

Contents

The Torbay Child Safeguarding Practice Review Panel met and carefully considered the report with the understanding and acknowledgement that it had been a significant period of time since the serious safeguarding incident that prompted the learning review. The learning review had been delayed at the start and took six months to complete.

The recommendations from the report were fully considered in August 2020 and a single agency and multi-agency action plan was created acknowledging that there is still more to do in terms of partnership and multiagency working. The New Safeguarding Partnership arrangements will hold the strategic responsibility for the implementation and oversight of the multi-agency learning that has arisen from this and other learning reviews.

It was acknowledged that a main area for recommended action had already received a significant amount of development, improvement and on-going quality assurance.

The Children's Social Care Practice Improvement Plan with its oversight and challenge from the improvement board had identified and actioned a number of key changes. Specifically the MASH processes and practice has been subject to review in October2019 and continues to be scrutinized through a regular examination of the data and dip samples of case with children and their families.

The resolution of professional dispute is work that is underway and an ongoing area that requires significant improvement.

Preface

The subjects of this review are C67 and C68 who are brother and sister.

C67 who was aged nine at the time that the incident happened has been described by those that knew her as a bright and articulate girl with a great sense of humour. Whilst she exhibited continuous behavioural problems during the period designated for this review those that worked closely with her have since identified that her demeanour must have been a sad reflection of the helplessness and frustration that she must have felt due to the circumstances in which she found herself.

C68 who was aged twelve at the time of the incident has been described as a timid and withdrawn boy who loved to escape reality through playing computer games. He loved mathematics at school and going to Boys Brigade. C68 whilst initially showing signs of concerning behaviour has since integrated well into school and has been progressing well in terms of academic achievement and his own personal development.

1.0 Introduction

1.1 This is the serious case review report of an incident involving C67 and C68, which was undertaken on behalf of the Local Partnership Safeguarding Children Board. This review examines the multi-agency response and support that was provided to C67 and C68, and their family prior to an incident when C67 was taken to hospital which occurred on the 22nd January 2018.

1.2 The key purpose of this serious case review was to;

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted on, 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.

1.3 Serious case reviews should be conducted in a way which[1]:

- 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
- makes use of relevant research and case evidence to inform the findings.

1.4 This serious case review was not initiated as part of any disciplinary process. However, had information emerged during the course of the review that may have indicated that

[1] Working Together to Safeguard Children (2015) ; now (2018).

disciplinary action was required, then individual agencies would have been asked to consider their own procedures.

1.5 This report considers the contact and involvement that agencies had with the family of C67 and C68 between the dates of 7th April 2017 (when the initial assessment of C67 was closed) through to the 22nd January 2018 as this was the date that C67 was admitted to hospital.

1.6 In addition to agency involvement this review has also sought to examine relevant background information and explore a hypothesis that local professionals have the ability to recognise concerning sexualised behaviour but are not able to articulate their professional judgement or give sound rationale to support action being taken. This refers to disproportionate weight given to a disclosure and physical evidence as opposed to professional opinion and the signs of impact trauma and abuse.

1.7 The review was also asked to consider the effectiveness of the local Professional Differences (Escalation) Policy to establish whether there is a lack of confidence in invoking the policy by practitioners.

1.8 By taking a holistic approach this review has attempted to identify appropriate solutions to make the future safer for children and young people.

1.9 Every effort has been made to conduct this review process with an open mind-set and avoid hindsight bias, and any other bias toward any one agency or individual involved.

2.0 Summary

2.1 C67 and C68 were both living in in a household together with their mother (MOC), who was aged fifty, and their father (FOC) who was aged fifty-three. At the time of the incident involving C67 she was aged nine and her brother was twelve. An elder brother aged twenty-one lived with his paternal grandmother elsewhere in the country.

2.2 The family had been known to Children's Services following an initial referral in 2009. After that date, and as a result on their interaction with the family, professionals from a number of agencies (Education, Social Care, Health) continued to raise concerns about the levels of neglect within the family and negative parenting. The concerns of neglect related to all of the members within the family household. In response to these

concerns those within the household were offered a range of family support services from both the statutory and non-statutory sectors. During this time there was a divergence of views amongst the agencies with regards to the levels of parental engagement and their ability to change their behaviour and improve the environment in which they lived.

2.3 Despite agency involvement C67s' behaviour within school continued to raise concerns. C67 was continually aggressive and violent to both staff and other pupils and used sexualised behaviour and language that was inappropriate for her age.

2.4 On the 11th September 2017 a strategy discussion took place due to the concerns that were being raised by Education professionals but this concluded that there was no physical evidence of harm and no specific disclosures had been made. A Section 47 enquiry[2] due to C67's vulnerability to Child Sexual Exploitation (CSE)/Child Sexual Abuse (CSA) and increasing risk of becoming criminalised.

2.5 On the 2nd October 2017 both of the children became the subject of child protection plans under the category of neglect. A review child protection conference was held on the 18th December 2017 where the category was changed to a risk of emotional harm.

2.6 On the 22nd January 2018 C67 presented at school with her mother saying that she had fallen and had bruised her genital area. When blood was seen on her underwear C67 was taken to hospital and following an examination it was identified that she had injuries to her bottom and vaginal area. Medical professionals conducting the examination concluded that the injuries were non-accidental and had been caused through blunt force trauma.

2.7 Both C67 and C68 were accommodated by the Local Authority in separate placements and an interim care order (ICO) was granted in February 2018. A police investigation was also commenced but to date those investigating the incident have been unable to ascertain how the injuries had been caused and by whom. No one has been charged with offences relating to the injuries that C67 sustained.

3.0 Timescales

[2] *A Section 47 enquiry means that CYPS must carry out an investigation when they have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.*

3.1 This case was considered at the Partnership Serious Case Review (SCR) Subgroup on the 7TH February 2018. Following careful consideration of the SCR criteria, (as set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006) and following further discussion the Independent Chair of the Safeguarding Children's Board was satisfied that there was evidence to support that the threshold for 'serious harm' (Working Together 2015) had been met.

3.2 The Independent Chair recommended that the circumstances leading to C67's injury be explored through a serious case review. This decision was supported by the National SCR Panel on the 28th February 2018.

3.3 The lead reviewer was appointed on the 24th May 2018 and the review was commenced on the 21st October 2017. The delays in appointing the lead reviewer and commencing the review were due to the ongoing police investigation.

3.4 On the 19th March 2019 the first panel meeting was held but the review had to be further postponed in light of additional information coming to light that could have progressed the police investigation. The review recommenced in July 2019.

3.5 The review concluded on 4th March 2020.

4.0 Confidentiality

4.1 The findings of this review are confidential. The Information obtained as part of the review process has only been made available to participating agencies, and the appropriate professionals within them.

4.2 The content of the report has been anonymised to protect the identity of the victim, perpetrator, relevant family members and all others involved in this review. The pseudonym/s are as follows;

Family composition and pseudonyms used;

- Victim – C67.
- Victims sibling - C68
- Victim's mother – MOC.
- Victim's father - FOC.

5.0 Methodology

5.1 The Partnership Safeguarding Children's Board determined that a systems approach should be utilised to move beyond the specifics of the case and to determine the deeper underlying issues that are influencing practice more generally.

5.2 The aim of the review was to look openly and critically at individual and organisational practice to see whether the case indicated that changes could or should be made to agency policies and practice, in order to improve the frontline delivery of services.

5.3 The Board arranged for all relevant agencies to check their records about any interaction that they had with the family. Where it was established that there had been contact, the Board ensured that all agencies promptly reviewed relevant documents, and they were then asked to provide a chronology detailing the specific nature of that contact.

5.4 Each agency's chronology covered details of their interaction with C67, C68 and their parents, and whether they had followed internal procedures.

5.5 In addition to the chronologies that were submitted the report writer reviewed relevant minutes from meetings and previous serious case reviews[3]. Where necessary specific professionals were individually interviewed to clarify issues that were identified in relation to agency response. Policies and procedures were also reviewed.

5.6 A multi-agency workshop was also held which involved those frontline professionals that had interaction with the family.

5.7 The MOC and the FOC were also spoken to on an individual basis as part of the review process.

[3] Serious Case Review Overview Report Child JS (2008); Serious Case Review C18 (2010); Serious Case Review Overview Report Child 24 (2011); Serious Case Review Child C40 (2014); Serious Case Review C42 (2014).

6.0 Author of the Overview Report

6.1 The Partnership Safeguarding Children Board appointed Paul Northcott as the independent author of the serious case review report on 24th May 2018. Paul is a safeguarding consultant specialising in undertaking safeguarding reviews and currently delivers training in all aspects of safeguarding.

6.2 Paul was a serving police officer and had thirty-one years' experience. During that time he was the previous Head of Public Protection, working with partner agencies, including those working to deliver policy and practice in relation to child safeguarding. He has also previously been the senior investigating officer for complex child abuse investigations and homicides.

6.3 Paul left the police service in February 2017 but had spent the previous seventeen months working regionally and nationally prior to that time. During that time he had no involvement with local resources or the policy and practices of the Devon and Cornwall Police. Paul also had no operational oversight of the resources that were deployed in this case during the period covered by the terms of reference.

7.0 Equality and Diversity.

7.1 This review adheres to the Equality Act 2010 and all nine protected characteristics (age, disability, gender re- assignment, marriage and civil partnerships, pregnancy and maternity, race, religion and belief, sex or sexual orientation) were considered by the report writer as part of the terms of reference and throughout the review process.

7.2 All members of the family were white British nationals. Their religious and philosophical beliefs are not known but there has been nothing identified as part of this review that would indicate that such beliefs impacted on their life choices or the services that they received.

7.4 No barriers to accessing services in relation to inequality were identified.

7.5 The review process found no evidence that the family were directly discriminated against by any individual or agency based on the nine protected characteristics.

8.0 Panel Members

8.1 The review panel consisted of the following members;

- Designated Nurse for the relevant Clinical Commissioning Group (CCG)
- Business Manager for the relevant Local Authority
- Local Authority Partnership Co-Ordinator
- An independent Education Dedicated Safeguarding Lead (DSL)
- A detective Chief inspector for the Police
- Head of Service, Safeguarding and Quality Assurance

8.2 In addition to the panel members the report was reviewed by an independent Head of Operations, CAMHS and Specialist Children's Services.

9.0 Overview

9.1 This overview will summarise what information was known to the agencies and professionals involved with the family and includes detail imparted by the FOC and the MOC.

9.2 C67 and C68 lived in a three bedroomed house, together with their natural parents. The family had lived at the premise for nine years. Professionals described the house as very dirty, chaotic and totally neglected (home visit 01/04/17 -Education). The interior of the house was dark and all of the rooms needed to be redecorated. The air within the house was described as thick with damp and mould. There was no apparent stimulation for the children in that there were no toys or games in any of the rooms. Clothes and belongings were strewn about the house, and there was cat faeces on the carpets and a strong smell of urine. There was also reports of fleas.

9.3 Those professionals who entered the house described it as dark, poorly decorated and there were no toys visible. The FOC described how he and his wife would struggle to maintain an adequate and safe environment for the children and that on occasions a relative would assist with housework.

9.4 In terms of sleeping arrangements both C67 and C68 had their own bedrooms.

9.5 C67's bedroom was described as unclean and dirty. There was nothing welcoming about the room and it had a bare carpet. When Social Care professionals visited the bed would be unmade and there was clutter on the floor. They described the room as 'not reflecting her identity'. Reports show that C67 originally slept on top of a bunk bed but this had been later changed to a single bed.

9.6 C67 has been described by Education professionals as extremely bright and perceptive. She was articulate and would often read books. C67 was also described as having a great sense of humour. She did however have low self-esteem and struggled to mix with her peers. Her Boxhall profile[4] (20th Sept 2016) described her as

- Insecure, fragile self-image and self-defeating attitudes
- Profound lack of trust in others and resists making an attachment
- Feels undervalued and is nursing a severely injured sense of self. This is expressed in self damaging anger

9.7 C68 was described by professionals and his mother and father as the polar opposite to his sister. He is quiet and unassuming. Teachers working in his primary school stated that could come across as '*Nerdy'* and overly helpful'. His friendship group whilst at primary school were girls. Concerns had been raised as far back as 2009 about him engaging in sexualised behaviour.

9.8 Since moving to a comprehensive school C68 has been described as settled and a model pupil although he doesn't openly share his feelings. Unlike his sister C68 has no self-esteem issues. C68's main passion is to play computer games which according to professionals he uses to escape reality.

9.9 The children lived in what was described by professionals as a dysfunctional household where the relationship between their mother and father had broken down. Agencies described their parents as showing little emotional warmth and their mother would often shout at the children. The MOC would often present to some professionals as angry and argumentative, particularly to those members of staff who were in C67's primary school, and to others she would readily comply with their requests.

[4] Boxall Profile - Online assessment tool for social emotional and behavioural difficulties for children and young people.

9.10 The MOC of the child was known by agencies to be the dominant force in the family (FIT assessment 2016/17) and was described by C68 as being overly protective of him. A report by the family support worker in 2012 (3rd May 2012) identified that the FOC would not challenge his wife about her parenting skills despite him being aware of the negative impact that this was having on C67's behaviour. He was described by FIT workers as ineffectual (single assessment June 2017).

9.11 The MOC demonstrated clear signs of frustration when dealing and interacting with C67 and this was witnessed by staff at the primary school. There were also many occasions where the MOC would refuse to deal with her daughters behaviour often blaming the primary school for the concerns that were being raised and stating that it was down to bullying (interview with MOC, although there was no evidence of this from school records). The FOC explained that the MOC would simply state that she would not attend C67's school despite being asked to do so in the hope that teaching staff would address C67's behaviour prior to her returning home. The MOC would state to those professionals who were working with the family that C67 would not display disruptive and sexualised behaviour at home.

9.12 It was believed that the FOC had little control within the relationship although the narrative from the MOC was that she would need to seek his permission before any decisions were made. The FOC stated that he would simply work and then come home leaving his wife to predominantly take care of their children. The impression provided by him was that he tried to avoid any form of confrontation at all costs and simply wanted a quiet life.

9.13 The FOC when spoken to as part of the review stated that he felt that he was a lodger in his own home and that he would hide himself in his bedroom. On reflection he concluded that he had taken his 'eye off the ball' in that he made few decisions about family life and that he was not actively involved in the daily activities of his children.

9.14 The FOC stated that on looking back he wasn't sure that they were ever suited as a couple. He stated that after the MOC fell expectantly pregnant with the brother of C67 and C68 the two of them had married. At that time he didn't feel ready to be a father.

9.15 When spoken to the FOC stated that their relationship had broken down some nine years previously and the two of them essentially led separate lives. The FOC stated that his wife slept on the settee in the living room area and that he slept in the main bedroom. He claimed that whilst his wife would say that this was due to her going

through the menopause and that she was constantly feeling hot he felt it was purely to avoid contact with him.

9.16 The MOC and the FOC would appear to have few friends and a limited social life. The FOC liked to go to the pub on occasions whilst the MOC liked to play bingo. The FOC worked in a local slot machine casino and the MOC has stated that she would occasionally work in a charity shop although the majority of her time was spent at home. There was a limited income coming into the household.

9.17 When asked what they did as a family the FOC stated that they would go on holiday to Blackpool and Dawlish and that they would go out into town together on occasions.

9.18 Professionals describe how there was little stimulation for the children within their home environment. The FOC has however stated that he and his wife would play computer games with the children and that the MOC was good at reading to them. The FOC also stated that the MOC would play board games and complete jigsaws with the children (although professionals going to the home saw little evidence of these activities taking place).

9.19 The family had been known to Children's Services since 2009, and this was due to concerns about neglect and negative parenting. As a consequence the family had received support from Children's Social Care and Health services. During this period core assessments were completed and the family had early intervention and Family Intervention Team (FIT) support. It was reported that following this intervention agencies had seen 'sustained positive change by parents (Single Assessment – 17th January 2017).

9.20 The two children attended the same primary school (C68 from the 2nd April 2012 until 26th August 2017 and C67 from the 5th September 2012 until the 26th September 2017). Both C67 and C68 had good attendance records but they would regularly turn up for school unwashed and in a dishevelled state. There were also continuing concerns raised by school in relation to the children turning up tired and unable to effectively study. C67 would often have to lie down in the reading corner in the school to rest and catch up with sleep (January 2016). Concerns were also raised that both of the children were not receiving a nutritional diet (9th May 2017-School).

9.21 Whilst at primary school both C67 and C68 used inappropriate sexualised language from an early age (2009). As C68 became older his behaviour changed and once in

the secondary school environment no further concerns were raised by those professionals who were teaching him.

9.22 C67 however showed increasingly aggressive and sexualised behaviour in the classroom. This behaviour included assaulting her peers and teaching staff on a daily basis and had escalated in its frequency and severity in the time frame covered by this review.

9.23 Due to her behaviour C67 was given intensive one to one support within her school however she continued to assault those around her. As a result of the level of risk to her peers and members of staff she was permanently excluded from school (as detailed in the section 10.0).

9.24 Following her exclusion C67 had to attend a specialist centre for young people experiencing complex social, emotional and mental health difficulties, before being moved to another school to continue her education. Whilst she responded well to these changes those professionals working with her continued to be concerned about her behaviour and the underlying causes behind it.

9.25 On the 22nd January 2018 C67 attended her school together with her mother and it was alleged that she had fallen and had bruised her genital area. On ascertaining the true nature and extent of the injury C67 was taken to hospital by teaching staff and following examination it was identified that she had injuries which were considered by medical professionals to be non-accidental.

9.26 After concerns had been raised a further assessment was undertaken and both children were taken into care. Care proceedings were then initiated by the Local Authority.

9.27 Following the incident both parents have separated. The FOC has stated that in his view he is better off separated and living a ‘single man’s life’ then he was staying in the relationship and that he is grateful that the children were taken into care in terms of their own welfare and support.

10.0 Condensed Chronology

10.1 Whilst the terms of reference are specific in relation to dates it was felt that a short summary of previous concerns should be included in this section of the report as they were seen as relevant by the review panel. These included;

2009 Referral from primary school – C68 showing sexually explicit behaviour.

2011 C67 attended A&E - Cuts to buttocks/Vagina. Injuries deemed to be accidental. Core Assessment undertaken which resulted in early intervention through family support and parenting.

2012 Concerns raised by SureStart regarding negative parenting (Emotional Impact C67). Parents had significant support by SureStart. *Children and Young Person Services (*CYP*S)* records state that 'the father has some insight as to the impact of mother's behaviour and parenting style but is not able to challenge her. Further core assessments were completed which by January 2013 identified sustained change by the parents.

2015 Referral from C67's school- Disclosure from C68 that there had been a sexual incident involving his sister and a friend when his friend stayed over. C67 had offered the winner of the game that they were playing sex and his friend accepted. The children were described by C68 as lying on the bed with clothes on and moving up and down. He stated that the other child had sex with his sister. S17[5] assessment undertaken. The MOC didn't want to pursue a criminal charge and was content with CYPS involvement. It was stated in CYPS records that there 'were concerns about C67s sexualised behaviour but no disclosures and no obvious reasons why she behaved in this manner. There was no further action taken in this matter as the school were closely monitoring C67.

2016 Early Help Assessment received from C67's school. The MOC had disengaged with support options. C67 had been excluded as she had assaulted teachers. At that time it was agreed that C67's school could remain the lead professional.

[5] Section 17 of the Children Act 1989 states that it is the general duty of every local authority to safeguard and promote the welfare of children within their area who are in need; and so far as it is consistent with that duty, to promote the upbringing of such children by their families

2017 (13/01/17) Referral from C7's school- Concerns raised about C67's sexualised behaviour- graphic conversation about sex and saying that her father and brother come into her room when she is sleeping (although she later denied this). CYPS records state that her school have significant concerns about C67's behaviour and their ability to manage it. A strategy meeting was held and the family were open to an assessment team until the 07/04/19. It was recorded that Targeted Help were to support the family when the case was closed.

10.2 Below is the condensed chronology of events that are relevant within the scope of the terms of reference.

Date	Episode or event of concern
18/04/2017	Education received a letter from Children's Services stating the case had been closed and there was no further involvement with Social Worker. The DSL from C67's school contacted the Family Intervention Worker regarding the schools concerns about this.
19/04/2017	School challenged decision by CYPS to close the case.
24/04/2017	Entry is CYPS records which states that they discussed personal space with MOC and she stated that the FOC 'does not get into bed with C67 now for cuddles' and she puts her to bed.
28/04/2017	Following increasing concerns about C67's heightened anxiety and needs, as well as further information C67's school agree to escalate the Safeguarding concerns. Multi Agency Safeguarding Hub *(*MASH*)* referral submitted.
08/05/2017	MASH referral regarding concerns raised by Personal, Social and Emotional Development (PSED) Team/ Young Men's Christian Association (YMCA) regarding general hygiene, head lice, tiredness and staying up late on iPad.
11/05/2017	The deputy head of safeguarding at school spoke to CYPS as they were concerned about the case being closed. CYPS records state that FIT work completed and as they 'works on consent basis there is no work identified to complete and no role for FIT '….this remains an education concern to be managed with a support plan and package.
12/05/2017	MASH Referral sent by school. SEN witnessed C67 being verbally aggressive to her dad shouting, 'Get away from me you freak'.
18/05/2017	C67 was violent towards a member of staff and was excluded 3.5 days.
22/05/2017	Child Adolescent and Mental Health Services (CAMHS) assessment reports that 'parent do not feel the need for CAMHS involvement and [MOC] refused to fill in questionnaires. The FOC did fill them in and the outcome showed no real issues which seemed incongruent to what school was seeing. The CAMHS worker stated that the parents were blaming the school.
23/05/2017	MASH referral put in by DSL.

25/05/2017	C67 attacked a member of staff with scissors. C67 excluded for 3 days.
28/05/2017	MASH referral sent by school.
30/05/2017	Referral from C67's school- escalating concerns about C67's behaviour which was becoming increasingly aggressive. C67 was having support from a specialist school and the YMCA. She was also seeing an Educational Psychologist.
31/05/2017	Decision by CYPS to undertake a single assessment.
01/06/2017	Single Assessment commenced(completed 22/08/2017)
13/06/2017	Review report received from the Outreach Service supporting C67. The report stated that C67 was interacting and having group sessions and presented no issues to them. C67 'shuts down' when you talk about negative behaviour or home life and will start talking in baby voice. Concerns with parents with regards to parent often appearing defensive.
22/06/2017	C67 shows sexualised behaviour in school including slapping bottom of Thrive[6] Lead and sexualised dancing. Hyper vigilance is escalating.
23/06/2017	Completion of 12 week specialist outreach work with C67 which reported high levels of concerns in 22 out of 46 areas and that there had been no improvement in her behaviour.
27/06/2017	PSED team reporting concerns that relationships breaking down where they had been positive as C67's threats increase and behaviour has changed again.
29/06/2017	C67 was violent to staff.
04/07/2017	School reported that C67'S behaviour was extreme and erratic on arrival at school.
05/07/2017	C67 repeatedly assaulted a member of school staff causing injuries. C67 excluded for 4.5 days.
07/07/2017	Special Educational Needs Medical Assessment conducted with C67 by a paediatrician diagnosed; 1.Challenging behaviour (with previous school exclusions) 2. Apparent avoidance attachment style with limited strategies for recognising and managing emotions.
12/07/2017	Multi Agency Meeting held at primary school. Apologies received from Social Worker. C67assaulted a member of staff and was permanently excluded.
17/07/2017	Specialist outreach school conducted a home visit. Professionals were shocked by the condition of the home. During the home visit the MOC raised her concerns that C67 had told her school that something bad had happened to her. On asked the MOC to explain further she said that C67 had told staff she had had sex with a T Rex. The MOC went on to say that she had never touched her children and told them about the incident that occurred in 2011.
17/07/2017	Specialist school made a referral to children's services. They were told that an initial assessment had been completed and that the case was closed.
22/08/2017	Single Assessment because of Child In Need. The outcome was continued Family Support.

[6] Thrive is a therapeutic approach to help support children with their emotional and social development.

11/09/2017	Strategy Meeting – Outcome – S47 enquiry due to C67's vulnerability to CSE/CSA and increasing risk of becoming criminalised.
18/09/2017	Child in Need (CIN) Meeting And Plan because of Child In Need. Outcome of Continue Family Support and move to Initial Child Protection Conference (ICPC).
27/09/2017	Allegation of Emotional Abuse with status of Substantiated. Decision of Case Conference.
02/10/2017	Initial Child Protection Conference (ICPC).
02/10/2017	ICPC – Concerns raised regarding C67s sexualised behaviour and language at school beyond a normal eight year olds understanding. It was noted that C67 stated "don't like it when dad comes into my bed", She has specifically talked about 'a willy going in her vagina'. C67 does not trust adults, little emotional warmth from parents to C67. Disguised compliance by parents. Decision to move to Child Protection (CP) Plan - Category of Emotional Abuse.
05/10/2017	C67 seen by support worker and would not discuss why she was worried. She said her worries were 'locked inside the worry monster'. Her family was discussed and C67 happily talked about her mum and brothers but refused to speak about dad saying only that she hates him.
10/10/2017	Core Group Meeting And CP Plan because of Child Protection. Outcome to continue family support.
13/10/2017	Planned home visit to complete family Health Needs Assessment. MOC reported that C67 has never not displayed any sexualised behaviour at home, and her behaviour at home has never been of concern.
16/10/2017	Core Group Meeting and CP plan. Parents and paternal Aunt in attendance. Outcome- Continued family support.
25/10/2017	Triple P[7] support started.
13/11/2017	Core Group held.
20/11/2017	C67's specialist school had seen a dramatic change in her behaviour describing her as swearing, threatening with scissors and emotionally dysregulated. The MOC was spoken to and stated that nothing had changed at home but went on to say that the only thing she could think of was that the FOC had taken her swimming on his own but that they had gone in separate changing rooms.
28/11/2017	Team around the Family (TAF) Meeting held to discuss school's concerns about C67.
11/12/2017	Core Group Meeting held.
15/12/2017	Single Assessment because of CP Review.
18/12/2017	CP review conference. Decision was made for the children to remain on a CP plan. Concerns raised that C67 is emotionally 'shut down' and seems more afraid of sharing her worries and feelings with adults. C67 has 'a fragile relationship with her dad. C67 has shown sexualised behaviours/used sexualised language and we do not know where this came from. Minutes state that 'We are worried she has been sexually harmed.

[7] Positive parenting programme.

27/12/2017	C67 referred to CAMHS after several angry/violent outbursts CAMHS felt she had the necessary inputs in place.
04/01/2018	C67's first day at a new school- phased start. C67 was full-time by the end of week 1. During this first week, C67 tried to run and scale the gate several times. C67 used inappropriate language and swore.
11/01/2018	Triple P Parenting Programme ends today.
13/01/2018	During TED[8] work, C67 made disclosure re brother and her dad coming into her bedroom and 'acting silly' and she does not like it but became very withdrawn and refused to talk about it more. C67 then stated, 'They've come into my bedroom whilst I was sleeping'. She then totally disengaged. This was shared with [Local Authority] Education Safeguarding Service (TESS), along with concerns about her increasingly violent behaviour. This resulted in a strategy meeting and a further assessment was agreed.
15/01/2018	Core Group meeting.
15/01/2018	Core Group
19/01/2018	C67 disruptive in school and assaulted a teacher. At end of the day the FOC attended to take C67 home. The FOC asked 'where my cuddles', and C67 are shouted 'No!' and ran away.
22/01/2018	C67 arrived ten minutes late with mum. Mum said C67 had slipped on a leaf and injured herself. Mum was very agitated. C67 was wiggling on her seat and referred to her bottom stinging, but not as much as the last time when she hurt herself on the telly. C67 went to the toilet and reported that there was blood in her pants. She said, "There's dry blood in my pants at the front…but it's drippy at the back." She reported "It's a bit sore, red and grazed." C67 first said she slipped on a leaf, then changed this to log and bush. CYPS records state that 'this is particularly concerning in the long history of concerns that she is being sexually abused'.
22/01/2018	Dr spoke to C67 asking her if anybody had touched her in her private areas. The MOC said she had been touched there when she hurt herself with the television - the Drs touched her then.
22/01/2018	The MOC was spoken to at the hospital and she was described as agitated saying, "They are going to blame me." Police records state that at hospital C67 'openly spoke about the bleeding from her privates but when asked if anything had happened such as anyone had touched her she closed down straight away and looked at her mum'.
22/01/2018	C67 had to wait for several hours for a female doctor. No social worker was available to attend hospital. Two teaching assistants had to stay with C67 for her physical examination. Throughout the day between 12 and 5.30 pm contact had been made with children's services. Education records state that C67's social worker was unavailable and the duty worker told the paediatrician to send C67 home.

[8] TED- Tasks for Emotional Development test. This test is designed to assess the social and emotional development and adjustment of children" by means of projective techniques.

22/01/2018	A doctor came to examine C67. Her mother accompanied her throughout the examination, as she was very distressed. Every time the Dr tried to talk; the MOC talked over her. It was hard for C67 to speak.
22/01/2018	Education/Health records state that Children's Services had told the hospital staff that C67 could go home. The paediatrician was not happy about this, so admitted C67 onto the ward for the night.
22/01/2018	The MOC was described as still very agitated, taking lots of phone calls from dad, crying and repeatedly saying she hadn't touched her children.
22/01/2018	School staff settled C67 into bed and left the hospital.
22/01/2018	C67 and C68 were already the subject of a child protection plan- following the assessment both were taken into care and proceedings were initiated.
23/01/2018	Education contacted CYPS to express concern that it was still school staff supporting C67 at hospital.

11.0 Analysis

11.1 This part of the overview will examine how and why events occurred, information that was shared, the decisions that were made, and the actions that were taken or not taken. It will consider whether different decisions or actions may have led to a different course of events. The analysis section will address the terms of reference and the key lines of enquiry within them. It is also where any examples of good practice are highlighted.

11.2 This analysis considers the previous sections within this report, the content of the chronologies that were submitted by agencies, and the feedback that was provided in the meetings held in response to this review.

11.3 Neglect

11.3.1 Nationally neglect is seen as the most prolific form of maltreatment and often presents that greatest challenge in getting a response from agencies and for professionals working with families.[9]

11.3.2 Concerns in relation to neglect had been raised as far back as 2011 by Health and Education professionals. These concerns had originated from an incident which had occurred at home when C67 had been injured after falling on an object and sustaining internal injuries which, following investigation, were deemed to be accidental. The details of this incident, whilst outside of the time parameters set for this review, become pertinent in relation to how some professionals later viewed C67's behaviour (this will be explored further in paragraph 11.7). The incident did however lead those that were involved with the family to be concerned that the children were not being effectively supervised or care for by their parents.

[9] *Nicolas (2016)*

11.3.3 Concerns had also been raised in respect of negative parenting and the fact that both of the MOC and the FOC were completely unmotivated to make any changes to their lives. The MOC was seen as dismissive of her two children whilst the FOC had little to do with them or any apparent influence in how they were being brought up.

11.3.4 From the conversations that took place with the MOC and FOC as part of this review it would appear that the MOC favoured C68 and consequently emotionally neglected her daughter. The level of emotional neglect and why it was occurring was never fully explored by agencies dealing with the family (as identified in minutes, the chronology and the practitioner's event) and this was a missed opportunity to identify some of the underlying issues affecting the family and the possible causes of C67's behaviour.

11.3.5 There was also physical evidence of neglect in that the appearance of both children was often poor, they were not washed and their personal hygiene was of a low standard. Records show that those in Education regularly saw the children in dirty clothes, with head lice and there were also concerns that they were not receiving adequate nutrition.

11.3.6 Professionals were also aware of the poor living conditions in which C67 and C68 lived in and this is evident in minutes of assessments and meetings. In line with practice numerous professionals (CYPS, Education and Health) did attended the home address. Social care professionals found the house to be in a poor state of repair and there were little signs of books and other items that would stimulate the children. As a consequence professionals had attempted to work with the family to improve their home environment.

11.3.7 Those professionals that were allowed into the house were often confined by the parents to the living room and they describe how all other doors would be closed prior to their arrival. Although there was a reluctance by the parents to allow professionals to see the rest of the house social care staff did ensure that all rooms in the house were checked. Such professional curiosity[10] should be seen as good practice.

11.3.8 All of the professionals working for the agencies involved in the case clearly recognised the signs of neglect and appropriately made referrals to the MASH. As a result of these referrals the family received support through the FIT. The level of support that was being provided by services in relation to the issue of neglect would appear to have been adequate and in line with the Partnership Neglect Strategy.

11.3.9 It would appear from the records made available to the review and from the practitioner's event that many of the professionals who had been involved in this case were seeing neglect as the primary issue which was affecting the family. The CYPS manager on the panel felt that often the term neglect was used in its wider

[10] Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value.

context and the understanding of interfamilial abuse was limited. As a consequence of this focus on neglect in this case and the absence of a disclosure those dealing with the family lost sight of the fact that sexual abuse could have been occurring in the family.

11.3.10 As a result of the failure to look at all of the available information C67 and C68's case was closed on the 7th April 2017. The consequences of this are discussed throughout the later sections in this report.

11.4 Parental Relationship and Behaviour

11.4.1 No one agency would appear to have had a full picture of the dynamics in the relationship or fully explored them with the couple. From the minutes of meetings, the chronology and the practitioner's event it would appear that the impact of the couple's behaviour on their children was therefore never fully assessed and the risks truly appreciated. In part this was due to both the MOC and the FOC failing to be honest with professionals, a lack of robust challenge and elements of disguised compliance (see section 11.5).

11.4.2 Due to the dominance of the MOC, and her attitude to her husband, professionals suspected that there may have been domestic abuse occurring in the household. A family support worker described how they felt that the MOC could be 'seen as a perpetrator of domestic abuse'. The level and type of abuse could not however be ascertained from agency records and from the practitioners focus group. There would appear to have been no further exploration in relation to domestic abuse by agencies. There were however no formal reports of such incidents and the MOC and the FOC where unlikely to have discussed such issues due to their mistrust of agencies.

11.4.3 Both the MOC and the FOC when spoken to as part of the review process denied that there was any violence or abuse occurring in the relationship. They also stated that the children did not witness any violence or abuse although both acknowledge that there were numerous verbal arguments between all members in the household.

11.4.4 Both parents contradicted each other with regards to who was the main instigator of the arguments. The MOC stated that the father used to shout at the children whilst the FOC stated that it was his wife. The FOC did however state that there were occasions when he would shout but intimated that this was at his wife. The FOC stated that such arguments would arise through frustration as on occasions he would come home from work and he felt that his own needs were being neglected.

11.4.5 The FOC stated that the MOC would regularly argue with C67 and would say that 'if anything was to happen to the kids she would fight for [C68] and not [C67]'.

11.4.6 In terms of abuse involving the children the FOC stated that he had witnessed his wife on one occasion (sometime after he had completed his Triple P Programme) grabbing hold of C67's hair and slamming her face into a chair. The MOC had done

this in retaliation to C67 spitting at her. This incident had never been reported to agencies.

11.4.7 The MOC was described by some professionals as argumentative, dismissive, defensive and immature. She was also seen as unpredictable when being approached about her daughter's welfare and behavioural issues. Professionals felt that the MOC was the sole disciplinarian in the household and that she dominated her husband in all areas of family life.

11.4.8 The MOC would appear to have exerted a consistent level of coercion and control over her husband (school entry dated 15/01/2018 and on his own admission) and this would constitute a form of domestic abuse. The MOC also exerted a similar level of control over her children.

11.4.9 Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another. The Cross-Government definition of domestic abuse and abuse[11] outlines controlling or coercive behaviour as follows;

'Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour'.

11.4.10 The impact of coercive control on an individual's mental and social wellbeing is now considered to be so serious that it became an offence in law in January 2016, under the Serious Crime Act 2015. Elements of coercion and control include;

- Deliberate use of alternative moods.
- Excessive jealousy and possessiveness.
- Isolation-preventing partner from seeing family or friends.
- Control of the partner's money.
- Control over what the partner, who they see, where they go, what they think.

11.4.11 In this case there were also elements of financial abuse in that the MOC had taken control over the bank card and would give the FOC what he termed as 'pocket money' each week.

11.4.12 Agencies also suspected that the MOC and/or the FOC controlled the behaviour of both children. Close working with C67 resulted in the YMCA stating that they believed that C67 had 'been trained to stay quiet when asked certain questions or when working with new people' (12th July 2017 multi agency meeting).

11.4.13 The FOC stated that on looking back at their relationship he believed that his wife was suffering from depression (there is mention of this in Health records in 2008)

[11] *Domestic Abuse; Home Office (2016)*

although he didn't recognise it at the time. He stated that her depression was due to the fact that she was unable to get over the death of her brother who had died some years previously in a car accident. From agency records (Health) it would appear that some level of depression was acknowledged but she was never formally treated for the condition.

11.4.14 Both the MOC and the FOC were known to drink alcohol although how this affected their behaviour towards C67 and C68 is unclear. Records do not provide an indication about how much they would drink, or how often and this would not appear to have been explored with agencies. Both parents when spoken to as part of the review process stated that alcohol did not play a big part in their relationship. The FOC stated that he was unable to afford to drink and that he never drank more than three pints of lager on any one occasion.

11.4.15 There is reference in CYPS records which states that C67 had stated that her father would enter her bedroom when drunk where he would then fall asleep. C67 also stated that her father would be annoying when he had been drinking. From the records seen as part of this review neither of these statements were fully explored in terms of the risk that it presented to her.

11.4.16 C67 graded her father as being two out of ten and stated that he would be ' drinking beer all the time, getting drunk.[and was] .annoying and silly'. She also described him as 'bossy, annoying and lazy'. There was no acknowledgement that these scores could have been attributable to abusive behaviour.

11.4.17 Although research is inconsistent there are findings that indicate that parental alcohol abuse can be associated with the sexual abuse of children[12]. The information disclosed by C67 in terms of how her father would behave when he had been drinking alcohol together with it being a known disinhibitor in terms of sexualised behaviour should have been explored further by agencies.

11.4.18 The FOC was asked why C67 would have rated him so low and he stated that he believed it was because he played his music two loud, that he would tell 'dad jokes' and that he would tell her off.

11.4.19 The FOC stated the he felt that he was largely unsighted about C67's behaviour. He stated that the MOC had kept much of the information about her behaviour from him. He was unable to provide a rationale as to why this had occurred other than the fact that she predominantly dealt with the child care issues. The FOC felt that he only found out about the extent of C67's behavioural problems when he attended one of the child protection conferences.

11.4.20 On review there is nothing to suggest that any one agency failed to effectively communicate with the FOC. For the school the MOC was the primary point of

[12] *Widom et al (2001)*

contact as the FOC rarely picked C67 up. Evidence in agency (Health, CYPS and Education) records would appear to show that he was kept informed.

11.4.21 From the documentation provided to the review it would appear that whilst professionals knew of some of the dynamics that were occurring in their relationship individuals providing support to the family did not have a full overview of exactly what was happening within the household. The meetings held as part of safeguarding practice did not illicit this information (see section 11.9 in relation to improvements required concerning practice).

11.4.22 In order to change their behaviour and assist the MOC and the FOC in coping with their children they were offered parental education programmes. There is no evidence that the MOC took up these opportunities but the FOC attended the Triple P parenting programme and an understanding your child's mental health course. The FOC stated that the Triple P Parenting Programme was particularly beneficial in terms of broadening his knowledge in how to deal with family related issues. The FOC stated that he felt that he should have been offered this course earlier and that this may have equipped him with the skills and knowledge that he needed to support his children more effectively **(Recommendation 1).**

11.5 Disguised Compliance

11.5.1 Agencies were initially positive in terms of the progress that the family was making following early intervention work. CIN work initiated in terms of concerns relating to neglect appeared to show positive results with agencies believing that the MOC and the FOC had responded well to the services that were offered and provided to the family. Records state that there 'were improvements in the family's relationships with each other and the home was cleaner and more welcoming environment.

11.5.2 As a result of the intervention taking place professionals working in agencies such as CYPS and C67's specialist school stated that both parents appeared to be listening to the advice that was being given and were making changes. Such changes led to the case being closed (11th May 2017) following single assessment as the MOC 'reported that things were fine at home and the challenging behaviours from C67 only occurred in school'. As a consequence this led to CYPS concluded that C67 remained an education concern to be managed with a support plan and package.

11.5.3 Conversely there were also concerns being constantly raised that the FOC was colluding with the MOC (report by family support worker in May 2012) and that they were exhibiting the traits of disguised compliance (CAMHS records 26/05/2017) Those that undertook the Triple P and Thrive programmes questioned whether the parents were truly engaged and those working in Education continually witnessed and were concerned about how the parents were presenting.

11.5.4 Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement. This was recognised in the ICPC held on the 2ND October 2017 when it was suggested that a

piece of direct work should take place with the parents to explore disguised compliance and an accurate understanding of the family dynamics. It is not clear from records that this piece of work actually took place. Nationally numerous serious case reviews have identified that the failure to identify those parents that are displaying false compliance and lead to an over optimistic view of engagement from family's and progress in terms of safeguarding outcomes for children[13]/[14].

11.5.5 In this case professionals displayed elements of over optimism[15] in terms of the MOC and the FOC having the ability to adequately look after their children.

11.5.6 What became clear from the practitioners events was that the behaviour displayed by their parents would vary considerably depending upon which agency they were dealing with. Those agencies that knew them well such as C67's school would witness the MOC being extremely volatile and aggressive on occasions. Often the MOC would minimise concerns and deny that there were any risks in relation to C67. It would appear that she would exhibit this behaviour in an attempt to avoid taking any form of responsibility for the way in which her daughter was behaving.

11.5.7 From the practitioners event it was clear that the MOC had developed positive relationships with certain professionals such as those working in Social Care as she knew that they would have an impact of her future with the children. The MOC was however hostile to many others, particularly those who challenged her. They describe her as being hostile, unpredictable and extremely argumentative. One professional described how her behaviour on some occasions boarded on being 'vile'. This type of behaviour was particularly evident to the staff at C67's primary school who repeatedly called her to account.

11.5.8 The persistence of the staff at the school in terms of trying to get the MOC and FOC to acknowledge and address the behaviour of their daughter should be seen as good practice.

11.5.9 Schools, Health and Social Care professionals recognised that there could have been elements of disguised compliance involved in their interaction with the parents and would act accordingly.

11.5.10 Whilst professionals were alive to the fact that both the MOC and the FOC could be non-compliant consideration was not given to fully understanding why this behaviour was taking place. If it was considered then the details were not fully recorded in agency records. The MOC constantly created confusion and disruption in an attempt to prevent professionals from developing a full picture of what was actually happening in the family.

11.5.11 In this case professionals were over optimistic about the progress being made within the family and the ability of the MOC and the FOC to adequately care for C67 and

[13] NSPCC Information Service (2014) disguised compliance: learning from case reviews London: NSPCC.
[14] Kettle, M et al (2017)
[15] The rule of optimism means that professionals are likely to give clients (parents) too many chances which is an adverse outcome for children in far too many cases.

C68. This was confirmed by the FOC who stated that little progress or change actually took place following intervention and in his belief agencies should have recognised this.

11.6 Evidence of Challenging the Parents

11.6.1 Despite the dominance of the MOC there was evidence of challenge by professionals. The staff in C67 and C68's primary school would try and talk to their parents in response to the concerns that had been identified. This is evidenced in school records and the full chronology (an example of which related to C68 when his parents were challenged as to why he was continually turning up at school tired). Engaging challenging and resistant families has been identified nationally as being key to improving outcomes for vulnerable children[16].

11.6.2 The ability to challenge and work constructively with the family was undoubtedly hindered by the unpredictability of the MOC's behaviour. The MOC would try and manipulate professionals and there would appear to have been an acknowledgement by many of the professionals that worked with the family.

11.6.3 Those professionals at the focus group stated that they were not concerned about the impact that challenge would have in terms of their relationship with the family. The information gained from the family and which is recorded across agency records should have provided sufficient information which could have been used to rigorously challenge both parents, particularly with regards to sleeping arrangements and possible signs of abuse (this will be explored in section 11.9).

11.7 C67 and C68's behaviour

11.7.1 Both C67 and C68 showed concerning behavioural traits which were recorded in agency records but not fully explored from a holistic multi agency perspective.

11.7.2 The FOC described C68 as being a quiet and laid-back child. In relation to his daughter however he stated that she would 'fly off the handle' and attack people at school, home and at his relatives address. He stated that she had threatened him three or four times with a knife (this information was not known to agencies). He couldn't recall seeing C67 attacking her mother but stated that he wasn't present in the house for the majority of time.

11.7.3 When asked why C67 acted like she did he stated that she was more intelligent than her years and that 'she felt that she couldn't control her emotions'.

11.7.4 C67's mother painted a different picture of her daughter. She had told those at her school that she never saw any violent or sexualised behaviour at home and on many occasions blamed the school for the way in which she acted. When interviewed as part of the review process the MOC did however recall two incidents where C67 had threatened her husband with violence. On one occasion she had tried to attack him

[16] *SJHeed (2012)*

with a screwdriver and on another with a knife. Again the details of these incidents are not recorded in agency records and demonstrate just how both the MOC and the FOC kept details from those professionals that they were working with.

11.7.5 Despite the interventions that were being put into place C68's behaviour continued to decline during the period covered by this review (as highlighted in outreach assessments 22/06/2017, THRIVE assessments 06/07/2017, Boxall profile 06/07/2017). C67 was physically assaulting and being threatening to both staff and pupils and despite her school working with her there would appear to have been no specific trigger events. C67 had also threatened to commit suicide. One to one working and specialist support all failed to identify the underlying causes that made her behave in the way that she did. Professionals described how she '*was emotionally shut down and scared to share her feelings with adults' (*Review conference 18/12/17).

11.7.6 The level of sexualised behaviour shown by C67 was also escalating in terms of the way that she was speaking and acting. All of this behaviour was not age appropriate and continually gave those working with her cause for concern in terms of sexual abuse. The MOC had initially explained that this behaviour could be attributable to C68 watching inappropriate videos on YouTube. When spoken to as part of the review she was adamant that the children hadn't watched anything inappropriate. This behaviour will be explored further in section 11.9.

11.7.7 A number of explanations were put forward to explain C67's behaviour including the possibility of her being autistic (originated from her parents) and /or suffering from the trauma in relation to an event that had occurred earlier in her life. The educational psychologist (Conference minutes dated 10th October 2017) stated 'her emotional development is delayed' and the 'root of her difficulties may be complex interaction of developmental/relational trauma and low levels of self-esteem and resiliency'.

11.7.8 The theory that her behaviour could be attributable to a traumatic event originated from the event in 2011. Health professionals however differed in their opinion as to the affect that this had on C67.

11.7.9 The evidence relating from trauma was however questioned (07/07/17) with a paediatrician stating;

> "*On the above evidence and discussion from professionals meeting I can see no other indicators at present for further assessment for an underlying disorder causing C67's present difficulties'*

In a letter to the GP (27/07/17 received on the 15/08/17) the paediatrician states;

> "*I am …… not consistently seeing evidence that supports a neuro-development disorder or post traumatic response*.'

11.7.10 From the information contained within Health and CYPS records the explanation of the possible causation of C67's behaviour in terms of childhood trauma would

appear to have clouded decision making and practice in terms of recognising and effectively dealing with the possibility of abuse within the family setting. None of the theories that had been identified would appear to have been fully explored and no autism assessment was carried out. The practitioner's event identified that no additional or long-term support or intervention had been put into place to address any of the issues that had been raised as possible causes of C67's behaviour.

11.7.11 C67 had been referred to CAMHS due to her complex behaviour and they had started to see her from February 2017. Whilst there were attempts to engage with her an entry dated the 26/05/17 states that the MOC had repeatedly told C67 that she did not have to talk to the CAMHS worker (this was later denied by the MOC. As a result of this repeated intervention by C67's mother CAMHS closed the case as they had concluded that c67 had no mental health issues and due to what they describe as non-compliance. CAMHS at that time suggested that health psychology team might be in a better position to work with C67 to address any possible trauma (related to the incident when she was two years of age).

11.7.12 A further referral had made to CAMHS but this failed to meet their threshold. Those at the practitioners group stated this would not be unusual in these circumstances as in C67's case there was no clear diagnosis of mental health and she was subject to social worker involvement. There is nothing to suggest that CAMHS had failed in terms of their obligations but practitioners felt that in the absence of any other specialist support for those with complex behavioural needs this was a missed opportunity to engage with C67.

11.7.13 C67 had also been the subject of an Education, Health and Care Plan (ECHP) and relevant assessments including oversight from an Educational Psychologist and whilst this had not identified the root cause of her behaviour some practitioners felt that this intervention could have occurred earlier **(Recommendation 2).**

11.7.14 As a consequence of the lack of clarity about her mental health needs there was no clear pathway identified to help support her. Those present at the practitioners event felt that there were delays in getting effective mental health advice and support for C67. Practitioners stated that this was a common occurrence for children with complex needs (**Recommendation 3).**

11.7.15 There was also an inability to gain C67's trust and disagreement amongst professionals as to why her behaviour was deteriorating which ensured that agencies continued to deal with her presenting needs and behaviours rather than fully considering other types of abuse. At the time neglect and emotional abuse appeared to be the primary factors driving decision making. In making those decisions the needs of C67 would appear to have been lost and she was not placed at the centre of practice. C67 would appear to have fallen between services in view of the inability to effectively identify the underlying causes of her behaviour.

11.7.16 Professionals at the practitioner's event agreed that C67 presented as a complex case with no one agency having the ability to effectively understand or diagnose the underlying issues that were causing her to behave violently and sexually. Due to

this complexity all practitioners acknowledged the need to work more effectively together and that opportunities to fully share information were not exploited (this will be explored further in later sections of this report).

11.7.17 The ability to help C67 and understanding what was making her behave in the way that she did was also compounded by the fact that she would on occasions fabricate stories (19/04/17). Reports from her primary school, the YMCA and the PSED team in her specialist school all state that C67 had been fabricating stories about going on holidays, events and trips.

11.7.18 Practitioners have stated that in complex cases like C67 there are limited options available to them for referral and support to other agencies (other than CAMHS), particularly in relation to those children and young people who are violent and require anger management services (**Recommendation 4**).

11.8 Support for C67 and C68

11.8.1 Professionals continued to try and engage with C67 throughout the time period covered by this review. C67's school were determined to try and prevent her from being permanently excluded and as a result had invested a great deal of time and resources in supporting her despite her levels of aggression and violence. They recognised that it was likely that school represented a safe place for C67 and despite the difficulties in managing her behaviour they felt that they were experienced at understanding her needs.

11.8.2 The school itself is experienced in dealing with families similar to this particular one and with children with behavioural difficulties. As a result they have introduced specialist staff and intervention strategies to enable them to cope with the demands placed upon them by children such as C67. These included

- multiple PSED check ins
- Three forty five minute nurture/counselling sessions per week
- Two forty five minute THRIVE sessions with a PSED Lead TPR.
- Four PSED check outs with an attachment worker.

11.8.3 The strategies used to help C67 also included funding specialist support from the YMCA. The school were particularly complimentary about the input provided by the YMCA in terms of their ability to interact and deal with C67. The level of commitment shown to C67 and the efforts made by staff members should be seen as good practice.

11.8.4 The investment made by one particular Community Care worker in the safeguarding and supporting families' team is evident throughout the chronology and from the minutes of relevant meetings and the practitioner's event it is clear that they were seen as a pivotal link with C67. The levels of support shown by this individual was exemplary.

11.8.5 As a result of C67's escalating behaviour and an inability to reach thresholds the primary school attempted to hold a multi-agency meeting. On this occasion they state that there was good attendance by all agencies except for social care. A social care representative would have been key to this meeting delivering effective outcomes in terms of the support that could have been offered to C67. Whilst there is an acceptance that there are finite resources with CYPS this particular meeting in terms of the level of concerns raised and the history of the family should have been prioritised. There is a feeling amongst agencies that where cases don't reach threshold and are held by single agencies there is limited support from CYPS (**Recommendation 5**).

11.8.6 To counter this the CYPS member on the panel has stated that there is often an expectation by schools for CYPS support although there are other avenues that are available and may be more suitable such as psychology and behaviour specialists. The panel member felt that schools need to be specific as to that support they are requesting.

11.8.7 Despite the considerable efforts of her primary school they were unable to keep C67 in mainstream education due to the level of violence that she displayed. On the 27th of September 2017 C67 was formally taken 'off roll'at her primary school and was permanently excluded due to her behaviour. At this point the school recognised that no matter how much intervention they had put into place they were unable to manage her effectively and safely within the school environment. This assessment was made after a sustained period of intervention by the school and in the interests of both the staff and pupils that she would have had contact with. In respect of the action taken and from the information provided to the review the school followed correct procedures and notified all relevant parties.

11.8.8 The FOC stated that in his view C67's school 'did what they could do under the circumstances' in fact he described them as 'doing a great job.'

11.8.9 On leaving her school C68 had been provided with additional support at a specialist centre for young people experiencing complex social, emotional and mental health difficulties. The aim of the centre is to support children to move back into mainstream provision or to another specialist school that can meet their needs. Keep safe work [17] was also conducted on a regular basis with C67. These were positive steps taken by those working in Education to ensure that C67's needs were specifically met with the aim of addressing her behavioural issues.

11.8.10 Although C67 was the only female pupil at the school there was provision with it to specifically support her. Prior to her arrival an assessment was completed and she was deemed suitable and capable of 'holding her own'. Staff at the school stated that despite her being the only female pupil she was not isolated and made some good friends. The alternative to this provision would have meant that she would

[17] Keep safe work- work conducted with children to reinforce boundaries and acceptable behaviour.

have had to be taught in the community where she would have been even more isolated and possibly at risk of further abuse.

11.9 Evidence of sexual abuse

11.9.1 There was no direct evidence that sexual abuse was occurring within the family environment. Neither C67 nor C68 had made any verbal disclosures to professionals that they were being physically or sexually abused.

11.9.2 The behaviour of both C67 and C68 did however cause concerns amongst those professionals that they came into contact with. Both of the children had displayed sexually explicit behaviour and language from an early age (2009). This behaviour was particularly evident to those working with the children in their school. This behaviour was clearly documented within their records and included;

- Sexualised language by both C67 and C68 beyond their years.
- Sexualised dancing by C67.
- C67 thrusting her hips in a sexual manner.
- C67 'snogging' her hand stating that she was practicing kissing.
- C67 kissing a member of school staff on the cheek.
- C67 passionately kissing dolls.
- C67 touching herself in a masturbatory way.

11.9.3 On 12th January 2017 C67 was writing a story about a monster named Rex. C67 stated 'that looks like sex' and when asked what she meant she replied' well it's when he puts his willy in my fanny. He can also kiss my fanny and the willy can also go in the bottom'. The staff member asked C67 what she meant by this and she stated that she had seen this and then named two children in her class. C67 then closed down and wouldn't say anything further. The matter was raised with TESS.

11.9.4 On the 13th January 2017 following advice from an attachment worker the school carried out a 'Three houses [18]'activity. C67 asked the person with her to draw her house and when she described her bedroom she went quiet. When asked if she had any worries about any of the rooms she stated' Well I don't like it when C68 comes into my room and swears and I don't like it when dad comes into my room and sleeps in my bed and acts silly.' When asked what she meant by silly she withdrew but later said 'they have come into my room whilst I was sleeping'. This information was shared with TESS and an initial assessment was carried out.

[18] Three Houses enables social workers to discuss a child's likes/ hobbies/strengths/protective factors, dislikes/worries & risks related to the child and dreams/hopes/wishes.

11.9.5 Within the school the staff worked hard to identify the causes of the sexualised behaviour and language working with both children to identify their concerns. In order to do this both children were seen on an individual basis and a variety of methods were used (as demonstrated above) to help them to articulate what was happening to them. On many occasions C67 was asked to talk about her negative behaviour and home life but in response would repeatedly regress to talking in a baby's voice.

11.9.6 Despite the attempts that were made neither C67 nor C68 disclosed the underlying issues that were causing them to behave in the way that they did. The school that both of the children had initially attended worked hard to create an environment within which the children could feel confident and comfortable to make disclosures should they have wanted to do so. This included one to one work particularly with C67. This approach should be seen as good practice.

11.9.7 Social Care professionals did view C67's sleeping arrangements but no one appeared to identify and collate all of the issues that would have caused concerns in terms of the risks of sexual abuse. These risks included

- Father allegedly entering her bedroom at night.
- FOC allegedly sleeping in her bed with her.
- C67 having to remove her father from her bedroom
- C68 waking her up to play hide and seek.
- C68 getting into her bed.

11.9.8 The sleeping arrangements in the house were not clear and concerns had been raised by individuals working with the family and through referrals. C67 had told professionals working in Social care that her father would sleep in the lower bunk of her bed (as discussed at ICPC 02/10/2017). This however contradicted C68's account who had described how C67 slept in bottom bunk as the top one was full of toys.

11.9.9 The FOC was challenged over his behaviour by CYPS and he admitted that he would sometimes get into bed with C67 when it was cold (although he denied that this took place when spoken to as part of the review). The FOC however insisted that his actions were not inappropriate.

11.9.10 C68 had stated that his father did not sleep in C67's bed but an entry in CYPS records dated the 24/04/17 demonstrates that both parents were challenged over this and the issues of personal space and that the MOC stated that the *'[FOC] does not get into bed with [C67] now for cuddles and [the MOC] puts [C67] to bed'*. The MOC on this occasion reiterated that everyone respects each other's space and C68 and C67 only go into each other's room when invited.

11.9.11 There is further evidence of this in the conference record stated 2nd October 2017 where it is recorded that [C67] says that she '*dislikes Dad in her bed'*.

11.9.12 There is little evidence in the information that was made available to the review that these arrangements were holistically considered, challenged further or regularly reviewed. There was also no evidence that agencies seriously considered these factors in terms of the possibility of abuse occurring in the household. If the parents were robustly challenged about the comments that were made then they were not recorded in the information provided to the review.

11.9.13 The issue of the children using sexually explicit language and exhibiting sexualised behaviour was explored in single assessments (17/01/17, 01/06/17) at strategy meetings (11/09/17), CIN Meeting (18/09/17, 11/12/17) core group meeting (16/10/17) and ICPC (02/10/17) but only in a superficial way. There was no real analysis of why it was occurring or formal recognition that abuse could be happening in the family setting. The mangers oversight in the CIN meeting (18/09/17) stated that ' the assessment has not evidenced that C67 has experienced sexual harm- which frankly is a worry that professionals have considered… however what has been evidenced within the assessment is that C67's behaviours are extreme and unexplained'.

11.9.14 The inability to comprehend the whole of the circumstances and history as documented in the records held by agencies led to a mixture of conclusions. In 2017 a single assessment was completed (01/06/17) which concluded that there was 'No evidence to suggest that C67 has seen or experienced sexual harm' and that 'it is my concern that should Children's Services involvement continue, the pattern of disguised parental compliance and [C67] being encouraged not to talk to professionals will also continue'. As a result the case was closed to the single assessment team at that time.

11.9.15 CIN, Strategy meetings and case conferences had concluded that C67's 'sexualised behaviour remained 'unresolved'. Despite concerns from individual professionals the underlying reasons and risks within the family were not fully explored and assumptions effectively challenged.

11.9.16 On the 11th September 2017 a strategy meeting was held in relation to C67's '*sexualized comments and unregulated behaviour which if they continue will increase her vulnerability to CSA/CSE and an increasing risk of being criminalised*'. This led to a decision being made that her case met the criteria for a S47 enquiry and on the 2nd October 2017 an ICPC was held and a unanimous decision was reached that there was a need for a CP plan under the category of emotional harm.

11.9.17 Many of the professionals that were spoken to during the review believed that in view of the extreme nature of her behaviour the escalation to a section 47 inquiry came too late and that previous interventions had failed to truly address the issues raised. This was commented on by the FOC who also felt that intervention by CYPS could have occurred earlier although when challenged he couldn't articulate why this should have happened.

11.9.18 As part of the terms of reference the review panel were asked to consider the following;

'Do …professionals have the ability to recognise concerning sexualised behaviour but are not able to articulate their professional judgment or give sound rational to support action being taken?'

11.9.19 This hypothesis was tested with staff at the practitioner event. Those present felt that they had the experience to recognise the signs of sexual abuse but stated that whilst they believed that sexual abuse was occurring in the household they felt frustrated as they were unable to prove it.

11.9.20 The South West Child Protection Procedures (2019) states that;

'*Children may disclose sexual abuse directly and verbally while others may attempt to disclose by non-verbal means including changes in their behaviours, requiring those around them not just to focus on the behaviour but why the behaviour may be happening*.'

11.9.21 From the details provided by practitioners and from the information gathered as part of this review it would appear that some professionals, whilst recognising the signs of abuse still lack the confidence to deal with situations where no formal disclosure has been made and find it difficult to identify the appropriate course of action that should be taken to protect the child concerned. The CYPS on the panel felt that professionals had become deskilled at responding to sexualised behaviour and sexual abuse (although Child sexual Exploitation response was clearer)- (**Recommendation 6).**

11.9.22 The disclosure of abuse to an appropriate person is often seen as key in commencing the process of protecting a child and can often provide professionals with the confidence and ability to mitigate risks, implement process and deliver effective safeguarding. Where such a disclosure is not made then professionals admit that child protection processes become infinitely more difficult to co-ordinate and deliver[19]. There continues to be a feeling amongst some staff that if the circumstances don't meet the threshold required by the judicial system (family court or criminal) then often they feel disempowered to act and fully intervene in family life.

11.9.23 Professionals found it difficult to fully understand C67's needs and despite numerous efforts they were unable to penetrate the barriers that C67 had built around herself. In this case it was commented by a CYPS manager that 'the inability of professionals to recognise possible sexual abuse has prevailed throughout this case and that this had a profound impact on how agencies responded to C67. The decisions made by agencies at the time have closed down subsequent inquiries of sexual abuse'.

[19] *McElvaney et al(2020)*

11.9.24 Whilst those involved in this case felt that they had adequate safeguarding training it has become apparent that this is somewhat generic in content and fails to adequately deal with such complex issues as non-disclosure in those cases where sexual abuse is believed to be occurring. There is also a lack of practical guidance readily available to staff. The South West Child Protection Procedures has only a small section in relation to the 'barriers to disclosure' and provides little detail or signposting for staff concerned about such issues (**Recommendation 7/8).**

11.9.25 The lack of confidence that some staff have was discussed at the Panel meeting where it was felt that too much emphasis is sometimes placed on reaching a court standard level of proof and on contravening the human rights of the parents. A senior manager within Social Care felt that in some cases such as this staff are failing to correctly follow the procedures contained in Working Together 2018. In this case panel members questioned why legal thresholds were being used at the referral stage. The expectation should be for an assessment with agency contribution and beyond the CIN status there may be enough to proceed to a child protection conference where legal requirements could be considered. The child protection plan dated the 11h December 2017 stated that a legal planning meeting would take place if 'concerns escalate'. Practitioners and managers have stated that there were continua attempts to escalate their concerns but there was a failure to listen to them.

11.9.26 The Partnership should ensure that staff are clear about the thresholds for evidence in criminal and civil proceedings. There should also be a particular focus on those cases where the evidential threshold for criminal proceedings is not met but the probability of abuse having taken place is high and what this means for decision making and practice (**Recommendation 9).**

11.9.27 In this case many professionals felt that whilst C67 had not made a formal disclosure she was actually attempting to reach out to them for help through her behaviour.

11.9.28 There were numerous opportunities for all professionals to share concerns and discuss the underlying causes of C67's behaviour and yet the processes that are currently in place did not appear to have facilitated such discussions. Professionals have been unable to articulate why this is the case but some felt that this was a reoccurring theme.

11.9.29 There was also an acceptance that those attending Core Groups, Strategy meetings and ICPC's should have a comprehensive oversight of all issues within a case. These forums however are often frustrated in delivering an effective service through time pressures, lack of attendance, poor information exchange and an inability to truly analyse the information effectively. In this case practitioners believe that there was a lack of effective information sharing and multi-agency discussion. In respect of the strategy meeting the CYPS panel member felt that the multi-agency discussion was lost due to the chaotic nature of the meeting, that C67's voice wasn't heard, and that no action was taken to limit the presence and influence of the MOC.**(Recommendation 10).**

11.9.30 Those at the practitioner's event were asked whether they believed that there was a lack of confidence amongst staff when dealing with adolescent children. There was agreement amongst those in the group that this was not a barrier to delivering support and services.

11.9.31 Both the MOC and the FOC when interviewed as part of the review process denied that any sexual abuse was occurring in the family.

11.10 Thresholds

11.10.1 In this case it was felt that the early referrals were not followed up effectively and this resulted in delays regarding statutory interventions.

11.10.2 Practitioners felt that the thresholds used by CYPS struggle to capture some forms of abuse and as a result some children falling outside of the criteria that has been set. This was true of C67's case. Numerous referrals had been made by those in Education (28/04/17) but their referrals failed to reach threshold within the MASH despite them feeling that they were comprehensive in relation to their content.

11.10.3 Practitioners felt that often the referrals are reviewed in isolation and a failure to consider the full history of a family. There is an acceptance that in order to be effective the MASH requires an holistic approach. Some professionals felt that there was an inability to get the case past threshold and that there was a failure of the MASH to fully appreciate the case in its entirety when making its decision. As a result C67's school felt that they were left to continually manage a level of behaviour which had reached such a level that they felt poorly equipped to deal with and where statutory intervention was required.

11.10.4 Within the threshold process practitioners believe that there is also no flexibility to provide allowance for professional judgement. In this case those working in C67's school were used to dealing with children with severe behavioural problems and they state that C67 was at the extreme end of the scale when compared with her peers. Despite the referrals that were made they felt that their professional voice and concerns were not being listened to. Practitioners felt that where referrals are made by those with substantial experience then the MASH should have the capacity and capability to speak personally to refer in such circumstances.

11.10.5 In this case the school felt that C67's behaviour had reached such a point that they had no choice but to consider using permanent exclusion in order to force decisions to be made about her care and for her voice to be heard. The fact that this course of action was even considered indicates that the current system of referral and levels of thresholds requires review (**Recommendation 11).**

11.10.6 Within the Local Authority concerned there is a recognition that there is no central team which is able to collate all of the information together and provide an holistic oversight to cases. Those on the panel felt that the Multi Agency Safeguarding Hub (MASH) had become a processing unit and had lost sight of the opportunities that

could be achieved through true multi agency discussion and decision making **(Recommendation 12).**

11.10.7 This case has left a number of professionals questioning whether agencies acted quickly enough and at the correct level. There was an acceptance that there was a great deal of activity by some agencies but that this may have provided false reassurance to some professionals. Many believed that the activity that was taking place was making a difference when clearly it wasn't in this case (as evidenced in C67's scores in her assessments). On reflection professionals felt that intervention should have occurred earlier through the correct application of thresholds.

11.11 Escalation and Assessment

11.11.1 Those at the practitioner event were aware of the escalation process and appeared to be confident in using it to address operational issues where agreement could not be reached. There is evidence recorded in agency records of the escalation process being used in this case (Education/SEN).

11.11.2 There were occasions however when the process was used by such agencies as Education but its effectiveness was frustrated by other operational practices. Interviews conducted with those working in C67's school identified that they had tried to escalate referrals and request a review of her case but that this had no impact (multi agency meeting 12th July 2017).

11.11.3 On occasions the schools efforts to escalate were frustrated as they were informed that their concerns would be addressed at the next formal meeting. Often these meetings were cancelled and therefore they had to commence the escalation process again in order to address the same issue. This is inefficient and could potentially place children and young people at risk. Effective supervision and oversight of cases should ensure that this does not take place and that escalations are dealt with immediately.

11.11.4 There is a clear escalation and professional differences policy should practitioners want cases to be reviewed in terms of their thresholds. These documents should be continually circulated to ensure that all staff are aware of their contents (**Recommendation 13**) and its effectiveness should be quality assured on a regular basis (**Recommendation 14).** The review identified that whilst professionals openly discuss escalation often some professionals fail to take the responsibility to do so or follow their actions through.

11.12 Managerial Oversight, Supervision and Workloads

11.12.1 Within the chronology there is evidence of managerial oversight and supervision taking place in this case, but on the detail provided it was difficult to assess the

quality of that input or whether it adhered to agency and the local partnership policy[20].

11.12.2 At present frontline staff with CYPS would appear to be highly committed and motivated. Feedback from practitioners has indicated that case load is not a particular issue at present but current bureaucracy within the system, created through performance management regimes, means that they are unable to have the time to effectively manage allocated cases and fully review all case documentation. Often professionals rely on verbal briefings from those already involved rather than looking at case papers. Such bureaucracy would appear to have increased as a result of the pressures brought about by the Authority being in intervention and the need to satisfy external scrutiny and inspection. One practitioner reflected that;

> 'so much emphasis is placed on form filling which simply benefits the system not the kids'.

11.12.3 In the light of this feedback the CYPS needs to continue to review current process to ensure that it's not adversely affecting the services which they are striving to deliver (**Recommendation 15).**

11.12.6 Effective supervision is therefore vital in allowing practitioners to have the time to read and understand cases and in ensuring that comprehensive summaries are completed. This is particularly important when there have been considerable changes in staffing with Children's Social Care which has on occasions created instability. Such supervision should ensure that there are comprehensive summaries **in** Child Protection Conference reports and that assessments provide sufficient information for professionals to make decisions. (**x ref Recommendation 15).**

11.12.7 There continues to be a feeling amongst frontline staff that Social Care have moved from preventative work to becoming purely a reactive service and therefore practices are currently failing children and their families.

11.13 <u>Post Incident Management</u>

11.13.1 Following the disclosure C67 was taken to hospital by staff from the educational establishment that C67 was attending. They were advised at the time that there was no one available from CYPS to take over this role. During the practitioners event it was identified that this was in fact not the case. CYPS representatives stated that they had made the decision on the information available at that time and that in their view it would be more effective if the staff members accompanied her until it was established what had actually happened. Those working in CYPS believed that this decision would be in C67s' best interests as she would be supported by people that she trusted.

[20] [Local Partnership]SCB Child Protection Supervision across the Partnership.

11.13.2 Those members of staff who accompanied C67 to hospital on the 22nd January 2018 felt that the lines of communication from CYPS were extremely poor and that they were ill-equipped to deal with the situation that they were faced with. They stated that this had been clearly articulated to CYPS. The members of staff who accompanied C67 felt that CYPS should have attended earlier to provide them with advice and guidance particularly about risk and the protection that she required (**Recommendation 16)**.

11.13.3 There was also confusion in relation to information sharing when C67 was taken to hospital. During the practitioners group it was ascertained that at the time those working at C67's school were concerned that the MOC was going to attend the hospital with her daughter and that this was inappropriate giving the circumstances and the possible nature of her injury. Whilst attempts were made to convey the seriousness of the situation to CYPS the MOC was allowed to travel with her and remain at the hospital (often alone with her daughter). At the time C67 had stated that she didn't want her mother present. In these circumstances this should be seen as poor practice and failed to reduce risk or give C67 any opportunity to disclose what had happened to her. The staff from the school felt that they should have been provided with specific advice on how they should have dealt with this situation. (**Recommendation 17)**.

11.13.4 The school had also contacted CYPS for an update in view of the impact that it was having on their staff who were at the hospital. On that occasion CYPS informed the school that they were unable to share any information about the welfare of C67 or circumstances due to data protection issues. Again this shows poor practice and awareness about the legislation as all agencies should have been working together at that time to deliver services in the best interests of C67 (**Recommendation 18)**.

11.13.5 During the practitioners event it was established that following the initial strategy discussion at the hospital there was a great deal of confusion about what was actually happening and whether the injuries that C67 had sustained were in fact non accidental.

11.13.6 The paediatrician involved in the management of C67's case raised concerns in terms of the decisions that were made by the children's services manager and police officer at the hospital. During the strategy discussion the paediatrician states that it was clearly discussed that there were concerns that 'there was a high suspicion of sexual harm occurring in the family'. All of those present accepted that there were many indicators of abuse but no disclosure by C67. The paediatrician stated that they had made it clear to those in the meeting that they had a high level of suspicion that C67 presented with injuries of sexual abuse and was advising that a specialist sexual abuse examination needed to be arranged immediately. The initial strategy discussion document states that the paediatrician was clear that C67 'needs to be given the opportunity to speak so that any abuse can be stopped'.

11.13.7 The strategy discussion concluded that there was ongoing concern regarding sexual abuse, that a specialist examination was to be requested to take place the next day

and that parental consent for that examination was to be obtained. Those taking part in the call discussed a place of safety for C67. The paediatrician then documented that the children's services manager said there is 'no disclosure, only suspicion of sexual abuse and therefore insufficient evidence to reach threshold for S47 and admit to place of safety'. It is further documented that the police and children's services manager felt that allowing C67 to go home that night placed her at no greater risk than the risk she has been at for the last few years. They concluded that legally they could not make her stay in hospital.

11.13.8 The paediatrician was shocked by this opinion and of completely the opposite view as they believed that if C67 went home, potentially to the perpetrator of the abuse, her safety was at great risk, as was evidence for the specialist examination the next day.

11.13.9 The paediatrician had a further concern in relation to the understanding of the police and CYPS representative in relation to the threshold requirements for a Section 47[21] inquiry, and the apparent influence that this had on their decision-making. They stated that on the day in question it would appear that the manager was of the view that the 'evidence' had to be a 'disclosure' or 'allegation' from C67 herself. The manager did not appear to consider any of the previous flagged or highlighted behaviours of C67 that other agencies had raised as signs of possible sexual abuse. It was the paediatrician's opinion that the manager appeared to hold the view that 'suspicion' of sexual abuse was not sufficient evidence to invoke the need to keep C67 in a place of safety whilst investigation took place. This was challenged at the time by the paediatrician and the issue was eventually resolved as C67 was kept at the hospital.

11.13.10 This issue was discussed at the practitioners event with no clear resolution. CYPS re-visited the meeting minutes and have since stated that it was the Police who had stated they could not do anything at this stage and therefore the child could go home (this is recorded on the Strategy discussion record). CYPS stated that were applying for an Emergency Protection Order (EPO) for court at the time and therefore they would not have sent the child home.

11.13.11 On the information available to the review it would appear that there was a lack of clarity in terms of the options discussed amongst agencies to protect C67 on the day that she presented with her injuries. The accounts provided by the paediatrician and social care vary which would indicate that either there was a failure to share all information or that the individuals misinterpreted what was being discussed. The records held of the conversations that took place would also appear to be inaccurate and subject to individual interpretation. It is essential when dealing with victims of abuse that all information is accurately shared, recorded and that this should take place in a timely manner (**Recommendation 19)**.

[21] A Section 47 enquiry means that *CYPS* must carry out an investigation when they have 'reasonable cause to suspect that a child who lives in their area is suffering, or is likely to suffer, significant *harm.*

11.14 Voice of the Child

11.14.1 There is evidence within the chronology that the children were being listened to and their views sought (single assessment 01/06/17). On the 18th November 2015, for instance, Children Services state that the children's wishes and feelings have been explored and they indicate that they are 'happy, loved and well cared for by their mother'. The level and detail of recording of their views was however inconsistent in much of the documentation that was reviewed (**Recommendation 20).**

11.15 Leadership

11.15.1 As a result of the review it has been identified that there is a feeling amongst staff that there has been a lack of leadership in terms of multi-agency working. Staff have recognised that there is a need for a commitment to a programme of development and learning which will take the Local Authority area forward in terms of robust working practices. The transition from a Local Safeguarding Children's Board to a Partnership has compounded this issue as has high levels of staff turnover. The new partnership is seen as an opportunity to rectify this situation and deliver effective training and development opportunities.

11.16.2 Senior managers within the Local Authority area accept that further work is required to develop and implement integrated pathways for children and their families to ensure effective outcomes in terms of safeguarding and child protection (**Recommendation 21).**

12.0 Conclusions

12.1 C67 and C68 were growing up in a dysfunctional household with little emotional support from their parents. The house in which they lived was poorly maintained and there were concerns from professionals that they were being neglected both physically and emotionally.

12.2 From an early age both children used sexually explicit language and behaviour which was considered beyond their years. Whilst C68 stopped such behaviour his sister C67 continued to become more explicit and violent as she progressed through primary school. This behaviour culminated in C67 being permanently being excluded from her school and being placed in specialist provision.

12.3 Neither C67 or C68 disclosed any physical or sexual abuse and their parents were unable to account for their behaviour.

12.4 The children and their parents had been known to CYPS over a number of years and had been receiving support prior to being placed on a plan initially for neglect and then for emotional abuse.

12.5 Despite considerable intervention by Education, Health and CYPS the underlying causes of the children's behaviour were never identified. There was an acceptance by those frontline members of staff who were working with the family that there was a great deal of activity in terms of working with the family but that this may have provided false reassurance to some professionals.

12.6 Those practitioners who have worked with the family have on reflection identified that statutory intervention could have occurred earlier and that this could have reduced the risk of ongoing harm to the children through the effective co-ordination of services.

12.7 In the absence of a disclosure by either of the two children, disguised compliance by the parents and an over optimistic view of progress within the family agencies lost sight of the fact that sexual abuse could have been occurring in the family. In this case there were risks identified which could have indicated that sexual abuse was occurring in the household and these were largely overshadowed by work to address areas of neglect, emotional abuse and C67's complex behaviour. There was a lack of understanding of the signs of sexual abuse and the interpretation of disclosure.

12.8 Some professionals, whilst recognising the signs of abuse, still lack the confidence to deal with situations where no formal disclosure has been made and find it difficult to identify the appropriate course of action that should be taken to protect the child concerned in such circumstances.

12.9 With no formal disclosure the judgements of some individuals were clouded by the need to reach criminal burdens of proof and there is a need for all staff to acknowledge and follow the basic principles as outlined in 'Working Together 2018'.

12.10 There were also delays in getting effective mental health advice and support for C67 and this is not an uncommon in the Local Authority area where this incident took place. A review of current pathways is therefore required.

12.11 Despite repeated attempts by those working in Education and Health there was an inability to raise this case to meet current thresholds on a number of occasions. This prevented earlier intervention by CYPS. There is there is therefore a need to review current thresholds and MASH working practices.

12.12 Multi agency working practices following C67's admission to hospital were ineffective and failed to work in accordance with local and national child safeguarding practice in terms of information sharing and the ability to protect C67 from those that could have harmed her. The initial strategy discussion procedures at hospital need to be reviewed to ensure that they are effective. Agencies need to review current practice in these areas to ensure that they are compliant with the South West Child Protection Procedures and Working Together 2018.

14 Recommendation

14.1 This section of the report sets out the recommendations made in relation to this case. It is acknowledged that since the commencement of this review agencies working within the Local Authority area concerned have made considerable advancements in improving practice but accept that further work is required to reach the standards expected.

14.2 The learning and any associated changes made to policy and practice should be disseminated through a Best Practice Forum.

Recommendation 1.

Learning: Parents require effective education programmes that are delivered in a timely manner in order to assist them in effectively coping with family life and improve the lives of children.

Recommendation: CYPS to review the current process of the allocation of parental education programmes (including Triple P) to ensure that they are delivered at the earliest opportunity.

Recommendation 2.

Learning: In this case practitioners felt that the Education, Health and Care Plan (ECHP) and relevant assessments including oversight from an Educational Psychologist should have been delivered earlier.

Recommendation: CYPS and Education to audit and review the effectiveness of Education, Health and Care Plan (ECHP) delivery and the availability of Educational Psychologist services within the Local Authority area for children with complex needs.

Recommendation 3.

Learning: In this case there were delays in getting effective mental health advice and support for C67 and this is not an uncommon occurrence for children in the Local Authority area.

Recommendation: CYPS and Health should review the current provision of mental health advice and support for children and young people within the Local Authority area to ensure that it is effective and delivered in a timely manner.

Recommendation 4.

Learning: Practitioners have stated that in complex cases like C67 there are limited options available to them for referral and support, particularly in relation to those children and young people who are violent and require anger management services.

Recommendation: CYPS to review and identify all available options to improve the current provision of services for adolescents with complex behavioural issues.

Recommendation 5.

Learning: Agencies have identified that where cases don't reach threshold and are held by single agencies there is limited support from CYPS.

Recommendation: CYPS to review current attendance practice with regards to early help/multi-agency meetings.

Recommendation 6.

Learning: Some professionals, whilst recognising the signs of abuse still lack the confidence to deal with situations where no formal disclosure has been made and find it difficult to identify the appropriate course of action that should be taken to protect the child concerned.

Recommendation: Local Authority partnership board to review current training and guidance in respect of non-disclosure issues in sexual abuse cases.

Recommendation 7.

Learning: The South West Child Protection Procedures lack specific guidance for staff on dealing with non-disclosure issues.

Recommendation: Local Authority Partnership to review and if appropriate amend the current South West Child Protection Procedures in relation to non-disclosure.

Recommendation 8.

Learning: There is a lack of confidence that decision making will be robust in similar cases where there has been a non-disclosure by a child but sexual abuse is suspected. Such cases need to be reviewed to ensure that children are not at risk.

Recommendation: Undertake a thematic review of an agreed (by Partnership Board) percentage of cases across the Partnership where sexual abuse is suspected but there hasn't been a disclosure.

Recommendation 9.

Learning: In this case practitioners identified that staff are unclear about the thresholds for evidence in criminal and civil proceedings in relation to child protection and safeguarding cases.

Recommendation: Local Authority Partnership to develop a communications strategy to reinforce to all staff the differences between thresholds in criminal and civil cases which reflects effective practice contained within Working Together 2018.

Recommendation 10.

Learning: Child Protection Meetings are often frustrated in delivering an effective service through time pressures, lack of attendance, poor information exchange and an inability to truly analyse the information effectively. In this case practitioners believe that there was a lack of effective information sharing at these forums. The effectiveness of these meetings needs to be reviewed.

Recommendation: All agencies to review current attendance and practice in relation to core meetings and case conferences to ensure that they adhere to best practice as detailed in Working Together 2018.

Recommendation 11.

Learning: In this case the school felt that C67's behaviour had reached such a point that they had no choice but to consider using permanent exclusion in order to force decisions to be made about her care and for her voice to be heard. The fact that this course of action was even considered indicates that the current system of referral and thresholds requires review.

Recommendation: CYPS to review current referral and threshold criteria for children with complex behavioural issues.

Recommendation 12.

Learning: Within the local authority concerned there is a recognition that there is no central team which is able to collate all of the information together and provide a holistic oversight to cases.

Recommendation: All agencies to review current MASH structure and practices to ensure that all available information is considered and effectively disseminated to facilitate effective decision making in terms of vulnerable children.

Recommendation 13.

Learning: Whilst most staff appear to be aware of the escalation and professional differences policy it should be continually circulated to ensure that all staff are aware of its contents.

Recommendation: Local Authority partnership to re-circulate the escalation and professional differences policy to all relevant agencies.

Recommendation 14.

Learning: The review was unable to fully ascertain the effectiveness of practice in relation to the escalation and professional difference policy.

Recommendation: Local Authority partnership to conduct an audit to ascertain the effectiveness of the escalation and professional differences policy.

Recommendation 15.

Learning: Current performance process within CYPS are adversely affecting the services which they are striving to deliver.

Recommendation: CYPS to undertake a review of current performance processes to ensure that are not adversely affecting caseload management.

Recommendation 16.

Learning: Members of staff who accompanied C67 to hospital on the 22nd January 2018 felt that the lines of communication from CYPS were poor and that they were ill-equipped to deal with the situation that they were faced with. Staff felt that CYPS should have attended the hospital earlier.

Recommendation: CYPS to review current practice in relation to staff attendance at hospital where there is a suspicion that the injuries sustained by the child are non-accidental.

Recommendation 17.

Learning: In this case the MOC was allowed to travel and stay with C67 despite concerns about the risk that she might pose to her daughter. C67 had also stated that she didn't want her mother present. Professionals failed to reduce risk or give C67 any opportunity to disclose what had happened to her.

Recommendation:

CYPS to review current advice given to agencies in situations where non accidental injury is suspected and parents are seeking to travel and stay with their children at hospital.

Recommendation 18.

Learning: The school had also contacted CYPS for an update and had been informed that they were unable to share any information about the welfare of C67 or circumstances due to data protection issues. Again this shows poor practice and awareness about the legislation as all agencies should have been working together at that time to deliver services in the best interests of C67

Recommendation: CYPS to ensure to increase staff awareness in relation to information sharing and data protection/GDPR.

Recommendation 19.

Learning: In this case the strategy discussion held at the hospital was ineffective and there was a failure to effectively share information. As a result C67 could have placed at further risk through being returned home to her family.

Recommendation: Police, CYPS and Health to review current strategy discussion and recording practice in relation to cases of suspected non accidental injury to ensure that it follows South West Child Protection Procedures.

Recommendation 20**.**

Learning: There was evidence that the voice of the child was not always consistently recorded in agency records.

Recommendation: All agencies to review current practice to ensure that the voice and wishes of the child are accurately recorded.

Recommendation 21.

Learning: In this case there was a disjointed approach to the delivery of safeguarding services to C67. Agencies working within the Local Authority area accept that further work is required to develop and implement integrated care pathways. Such pathways will deliver effective services and responses in respect of child protection and safeguarding.

Recommendation: CYPS to work with all agencies in the Local Authority area to review current service delivery and implement effective integrated care pathways to meet the needs of children and young people**.**

12.0 Glossary

CAMHS - Child Adolescent and Mental Health Services
CCG – Clinical Commissioning Group
CIN – Child in Need
CLA- Child Looked After
CP- Child Protection
CSA – Child Sexual abuse.
CSE – Child Sexual Exploitation
CYPS- Children and Young Person Services
DSL - Dedicated Safeguarding Lead
ECHP - Education, Health and Care Plan
EPO – Emergency Protection Order
FIT – Family Intervention Team
FOC – Father of the child
GSC- Government Security Classifications
ICO – Interim Care Order
ICPC - Initial Child Protection Conference
MARAC – Multi Agency Risk Assessment Conference
MASH- Multi Agency Safeguarding Hub
MOC – Mother of the child
NHS – National Health Service
PCT- Primary Care Trust
PSD - Personal, Social and Emotional Development Plan
SCR – Serious Case Review
SHA- Strategic Health Authority
TAF- Team Around the Family
TESS- [Local authority] Education Safeguarding Service
YMCA - Young Men's Christian Association

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