Windsor and Maidenhead
LOCAL SAFEGUARDING CHILDREN BOARD


# SERIOUS CASE REVIEW

# CHILD F

# SUMMARY REPORT

**Independent Lead Reviewer:**
**Moira Murray**
**April 2015**

## INTRODUCTION

### 1. Background to the Review

**1.1** This report will summarise the findings of the Serious Case Review which was conducted in respect of Child F for the period between February 2011 and January 2014.

**1.2** In February 2011 when Child F was aged 12, she was arrested with her Mother for shoplifting. At the police station Child F made a disclosure that her older brother, when aged 15, had anally raped her on two occasions over the previous two years. It was further alleged that that he had also physically abused her and had made threats to harm her. Her brother, 'B' was subsequently arrested and was bailed to live away from the family home, in the care of his Father.

**1.3** Child F later retracted the allegations, however, a Section 47 enquiry, the Children Act 1989 was initiated, which resulted in an Initial Child Protection Conference being convened in March 2011. There was concern that Child F had been under pressure from her parents and extended family members to withdraw her allegations. The conference decision was that Child F and her five siblings, including 'B' were at risk of significant harm and they were made subject to child protection plans, category sexual abuse.

**1.4** Given that Child F had made her disclosure following her arrest for shoplifting, had then withdrawn her allegations and 'B' had made no admissions, the Crown Prosecution Service decided there was insufficient evidence to charge 'B'. There was however sufficient concern about the risk posed to Child F and her siblings that the Child Protection Plan stipulated that 'B' should continue to live away from the family home until a core assessment and a specialist risk assessment had been completed.

**1.5** The specialist risk assessment found on the balance of probabilities that 'B' probably did commit the assaults. It recommended that 'B' start an individual programme tailored to his learning difficulties.

**1.6** During this period of 16 months there had been a disclosure from 'E', the youngest sibling aged 6 years, that she had been physically abused by her Mother. This allegation was subject to a single agency Section 47 enquiry; however 'E' remained at home.

**1.7** On reaching the age of 17, 'A' the eldest daughter moved out of the family home to live with her boyfriend, who was of a different faith and culture. This caused considerable difficulties for 'A' who faced threats of violence for her actions from extended family members. Child F was forbidden to have contact with her older sister.

**1.8** The social worker allocated to the family believed that during this time 'B' remained living away from the family home, as stipulated by the Child Protection Plan and Written Agreement. Additional concerns also identified by Children's Social Care (CSC) were being addressed. These included chaotic sleeping and living arrangements, all the children being over-weight and health and dental appointments not being attended.

**1.9** In January 2013 it was decided that all the children should no longer be subject to a Child Protection plan, but a child in need plan. This was because the consultants undertaking the specialist risk assessment concluded that 'B' presented a low risk of sexual abuse, although a monitoring plan would need to be in place should he return home. Agencies working with the family reported increasing engagement by the parents, despite their refusal to believe that 'B' had sexually harmed Child F.

**1.10** 'B' returned to the family home in September 2013. Child F's school attendance began to decline in the summer and autumn terms of 2013 and her appearance changed. She began wearing make up and dressed in western clothes. There was concern among some agencies that she may be subject to child sexual exploitation. In a strategy meeting Police were asked about whether Child F was in contact with a known sex offender, however there was no evidence to suggest that this constituted Child Sexual Exploitation. Following further Police investigations it became apparent that Child F's Father had been sexually abusing her. It also became evident that 'B' had returned to the family home when he had been forbidden to do so under the terms of the previous child protection plan and written agreement. Further allegations were made concerning 'B's sexual abuse of Child F.

**1.11** Child F and her siblings were removed from the care of their parents and made subject to care orders. Her Mother, Father and 'B' have been charged with criminal offences and are awaiting trial.

**1.12 FAMILY COMPOSITION TABLE**

| **Name** | **Relationship** |
|---|---|
| Child F | Subject of Review |
| 'A' | Sister |
| 'B' | Brother and alleged perpetrator |
| 'C' | Brother |
| 'D' | Brother |
| 'E' | Sister |
| | Mother |
| | Father |
| | Grandmother |
| | Aunt |

## 2. CONCLUSIONS

**2.1** This was a complex case of interfamilial abuse which was initially thought to only involve a sibling. It later emerged that Child F had been subject to sexual abuse from Father. Whilst this review has been unable to determine when the abuse of Child F by her Father commenced, it remains a possibility that it may have been happening for some time, and certainly during the period when Child F would have been under a Child Protection or Child In Need plan. That Child F was being abused by her Father was only discovered as a result of concerns being raised by Police that she was in contact with a convicted sex offender. Had Police not examined Child F's mobile phone in the context of this investigation then the fact that Father was sexually abusing her would not have come to light at that time.

**2.2** There were aspects of positive practice by some agencies in this case. Police rightly identified the special needs of 'B' and ensured that a social worker acted as an Appropriate Adult. Police and CSC were especially concerned that Child F was being subjected to pressure from the family to withdraw her allegation and undertook a joint agency interview. This was followed by Father being warned by Police not to intimidate Child F. Despite Child F withdrawing her allegation Police appropriately decided that the case should be put before the CPS for a decision as to whether 'B' should be prosecuted. The swift actions of both Police and CSC when Child F was fearful that she may be taken to Pakistan was in keeping with the Honour Based Violence protocol and is an example of good practice.

**2.3** School 1 monitored Child F and offered her support at times of crisis and reported all child protection concerns. The School Nurse carried out her responsibilities as prescribed in the Child Protection plan and acted swiftly and appropriately when she was concerned that Child F may have been sexually exploited. She was however lacking in knowledge and confidence on how to deal with sibling on sibling abuse, but has since accessed training.

**2.4** The Social Worker (SW1) undertook her duty to visit the children diligently and attempted to engage with the parents to improve the family's lifestyle. However, she faced a difficult task in having sole responsibility for six children on child protection plans, one of whom being an alleged perpetrator of sexual abuse, but also a child in his own right. The complexities of culture, language, learning difficulties, all feature in this case, but SW1 was also responsible for finding and commissioning a specialist risk assessment with little support from immediate line management or from the Child Protection Conference and the Core Group. There was no escalation of concerns by SW1's line manager or the Core Group when no decision on funding the assessment was forthcoming from senior management for twelve months.

**2.5** Unusually, there was continuity of social work involvement and supervision in this case. There was however an overall systems failure.

**2.6** There was no questioning of the appropriateness of the children being subject to child protection plans and the adequacy of the plans themselves, the delay in commissioning the specialist risk assessment, the delay in producing the assessment or the findings of the assessment report by any of the agencies involved. The case was allowed to drift for nearly two years whilst the children (with the exception of 'A') were on child protection plans, with responsibility and decision making essentially remaining with the social worker.

**2.7** It is concerning that there was no evidence of reflective supervision, challenge, holistic assessment or review of the case on the part of the responsible supervisor who was seemingly content for decision making to be left to the social worker.

**2.8** Unfortunately, Child F was left in the care of her parents despite the serious concerns of professionals that she remained vulnerable to abuse. It was known that 'B' was visiting the family home when he should not have been. Child F expressed her fears for her safety when 'B' was at home. She was later to describe violence perpetrated against her by 'B', but her requests to be removed from the care of her parents were not acted upon for several months.

**2.9** As stated above there was no escalation of concerns by any agency involved in the child protection process about the time it took for funding to be agreed for the specialist risk assessment of 'B'. Apparently, it was sufficient reassurance that as the perpetrator 'B', was living away from the family home Child F was protected.

**2.10** As has been evidenced in this review there was a lack of a suitable commissioning process for the specialist risk assessment of 'B'. This was followed by insufficient scrutiny and quality assurance of the report when it was presented to CSC who commissioned it and the Child Protection Conference which failed to question its findings. There was an over reliance on the need to wait until the outcome of the specialist risk assessment was known before decisions were made as to the direction of the case. However, once the assessment findings were delivered the recommendation that a risk management plan be put in place with social work intervention and monitoring was not followed as the case changed from being one of Child Protection to one of Child In Need. The allocation of the case to an Assistant Social Worker (ASW) at the very time when it could be said Child F was most vulnerable, was a flawed decision and appears to have been based on the case being stepped down from one of child protection to one of child in need. It is reassuring to note that under current arrangements no ASW has sole responsibility for a case.

**2.11** Throughout the period under review the parents maintained that Child F had lied about 'B' abusing her and supported him in his denial. Their refusal to acknowledge that 'B' had abused Child F was known by all agencies whilst she was subject to child protection. Even though they presented a semblance of compliance with the requirements of the Child Protection and Child In Need plans, Mother and Father prevailed in their support of their son, and thus could not provide Child F with the protection she needed to remain safe.

**2.12** Given that the family was not known to agencies until Child F's disclosure in February 2011 it would not have been possible to prevent her being abused by 'B' prior to that time. However, once the case became one of child protection, the further abuse which Child F sustained from her brother and her Father could have been prevented if she had been removed earlier from the care of her family. 'B' was essentially treated as an adult perpetrator, which meant that the focus was not on ensuring that Child F was adequately protected from abuse but that a means was found for 'B' to eventually return to the family. Unfortunately, this resulted in Child F being left vulnerable to an environment underpinned by fear, anxiety and sexual violence.

## 3. LESSONS LEARNT AND RECOMMENDATIONS

### EMERGENCY DUTY ARRANGEMENTS

An appropriately resourced and reliable Emergency Duty service including Appropriate Adults able to attend Police Stations is vital.

The lack of Emergency Duty cover and its impact, especially the availability of a Social Worker as an Appropriate Adult to attend Police interviews, was a significant factor at the outset of this case. The review heard that this is a situation experienced frequently by Thames Valley Police, and that this still continues.

Whether the provision of a Social Worker as an Appropriate Adult, when Child F was first interviewed at the time of her disclosure, instead of Child F's Father, would have prevented her return to the family home is a matter of conjecture. It would however have allowed her an opportunity to speak about the abuse she had experienced to an independent professional, and may have also enabled a joint section 47 investigations to have been undertaken over the weekend, instead of the following week.

**Recommendation 1**

That the LSCB call on Children's Social Care to review the current arrangements in place for Emergency Duty Team cover and take steps to address the shortfalls identified in this case.

**Recommendation 2**

That the LSCB commissions an audit of EDT activity and availability to seek assurance that the service is operating at safe and acceptable levels.

**Recommendation 3**

In cases involving alleged interfamilial abuse, a family member should not be used as an Appropriate Adult. Thames Valley Police to give consideration to the production of guidance which addresses these and other related circumstances.

### LISTENING TO THE VOICE OF THE CHILD

The need to listen to and believe children who disclose abuse is crucial if they are to be protected and their well-being promoted.

Although Child F withdrew the allegation of rape against her brother, it was clear to all professionals working with her that she did so under duress because of pressure from family members. This was manifest in the decision to place all six children on child protection plans and by seeking an expert risk assessment of 'B'. By disclosing what had happened to her, Child F expressed her hope that the abuse would stop. Unfortunately, this did not happen.

It is however recognised that Police and CSC worked together to protect Child F when she voiced her fear that she may be taken to Pakistan.

Even when Child F openly stated her fear of 'B' when he returned home in September 2013 and disclosed how he had attacked her, she was essentially not listened to by those in a position to remove her from this abusive situation.

Teachers and police officers were informed by CSC that Child F would be immediately removed from the family home. Social workers heard her distress and having agreed that Child F would be removed, did not do so, but proceeded to seek an agreement from her parents that they would protect her from 'B'. A decision which mirrored the previous child protection and child in need plans.

**Recommendation 4**
That partner agencies are asked to reassure the W&M LSCB that they have systems in place to gather and listen to the voice of children and young people, prior to making decisions for intervention.

## SPECIALIST RISK ASSESSMENTS

The delays in commissioning, completing, and the eventual over-reliance on a specialist risk assessment was a significant factor in the management of this case.

The review heard of the lengthy delay in the approval of funding to commission the assessment, and a subsequent extended time period in which the work was undertaken and reported. There was no evidence that this delay was being escalated.

When the work was completed its limitations were apparently not considered and it was relied upon to justify the ending of the Child Protection Plan status of the children and the return home of 'B'.

**Recommendation 5**
The W&M LSCB seek an assurance that Children's Social Care have undertaken a review of the effectiveness of commissioning arrangements for specialist risk assessments of children.

**Recommendation 6**
That those arrangements include the development of commissioning guidance for the engagement of specialist assessments[1], to include: consideration of timescales for funding, commissioning the appropriate agency to undertake the assessment and set timescales for the delivery of the assessment.

**Recommendation 7**
In circumstances where a specialist risk assessment is required that advice is sought and taken from the Designated Doctor as to which provider should be commissioned.

## DECISION MAKING AND FUNDING

Decisions about the appropriateness of a child returning home are fundamental and a delay in acting upon a decision that a child should not return home for her/his safety places that child at an unacceptable level of risk.

Child F was seriously let down by Children's Social Care. By returning her home, having assured Child F and professional colleagues that she would be removed, Children's Social Care enabled the abuse to continue for a further two months.

Whilst it cannot be said that the sole reason why Child F was returned to her parents was one of financial expediency, (there was no 'in house' foster placement available at the time and an expensive agency foster-carer would have been the alternative) it is vital that resource constraints do not impinge on the best interests of the child. This decision was not only professionally unacceptable, it took no account of what was in Child F's best interests and showed little regard for the main principle of safeguarding children, i.e. the welfare of the child is paramount.

[1] similar to that of the Law Society's Guidance on the appointment of expert witnesses

**Recommendation 8**
That W&M LSCB seeks assurance from Children's Social Care that decision-making regarding the placement of children away from the family home is not affected by any issues other than the welfare of the child, and that in particular financial matters do not impinge on decision-making or implementation of those decisions.

That W&M LSCB reminds partner agencies of the importance of listening to children and of their duty to act in situations where a child is at risk of significant harm. Where an agency has been informed that a child will be removed, but becomes aware that immediate action has not been taken, concerns about the child's safety should be escalated using the W&M LSCB Escalation Policy.

**Recommendation 9**
That an audit of placement decisions be conducted to provide assurance that delays are not occurring in securing safe placements where these are required.

## ISSUES RELATING TO INTERFAMILIAL ABUSE

There is a critical need to consider all of the children within a family where interfamilial sexual abuse has become known.

## THE PERPETRATOR AS A CHILD

The perpetrator of sexual abuse must continue to be regarded as a child and their needs appropriately considered.

Throughout the conduct of this case, 'B' appears to have been treated as a perpetrator, with little consideration given to his needs as a child. He was subject to a Child Protection Plan which focussed on him being restricted from living in the family home but did little in terms of exploring or meeting his needs.

Despite being on a Child Protection Plan little seems to have been achieved in safeguarding 'B's future and it is disappointing to note that now over the age of 18, 'B' is not in employment, education or training, and is the only member of the sibling group who continues to reside with his parents.

Seeing 'B' as a perpetrator and not as a child in his own right, who may have experienced sexual abuse himself, was compounded by an over reliance on the part of members of the Child Protection Conference and the Core Group on the findings of the specialist risk assessment. There was little or no challenge of the delay in commissioning and completing the assessment by any professionals. There was no questioning of the findings of the assessment, just as there was no questioning of the lack of provision of specialist therapy to either Child F or 'B'. It was accepted that 'B' presented a low risk and agencies involved in the case agreed that the case should be stepped down from one of child protection to one of child in need, at the very time when Child F was most at risk. This was an ill judged decision based on the findings of a risk assessment which essentially drew its conclusions from the previous six month period when 'B' was living away from the family home. Disguised compliance on the part of the parents also played a part.

**Recommendation 10**
W&M LSCB to review the appropriateness of procedures to ensure that:

- where there are complex cases of sibling sexual abuse, both victim and perpetrator are seen as children in their own right. As part of Child Protection/Child in Need Plan, an individual social worker should be appointed for the victim and another appointed for the alleged perpetrator,

- where children are in need of specialist therapeutic services arrangements are put in place to provide this facility in order to avoid children who have been involved in sexual abuse being left unsupported at times of crisis. This should apply to both victim and perpetrator.

**SUPERVISION AND MANAGEMENT OF THE CASE**

The absence of robust arrangements for reflective, but challenging supervision of professionals involved in this case was significant.

Challenging and reflective supervision for those holding complex cases involving child sexual abuse is vital, but was absent in this case. Holistic management of the case was lacking, which in turn allowed a situation where 'B', who was awaiting the outcome of a specialist risk assessment, to drift on for almost two years. This was detrimental to both 'B' and Child F. However, as has already been stated to expect an individual social worker to have what was essentially sole responsibility for a case as complex as this one was unrealistic and unworkable, and led to missed opportunities to fully assess the risk presented to Child F.

The need for professionals to have the confidence and the means by which to challenge such decisions is a lesson learnt from this review. It is somewhat reassuring to know that changes have been made and requests for the funding of placements for young people is now decided by a multi-agency panel on a case by case basis. However, if vulnerable children and young people are to be protected this process needs careful monitoring by all those involved.

**Recommendation 11**

W&M LSCB to seek assurance that an audit of social work supervision is undertaken, with the findings presented to the LSCB by Children's Social Care.

**Recommendation 12**

W&M LSCB seeks assurance that a training programme is in place for School Nurses concerning sexual abuse, including interfamilial and sibling abuse, and that safeguarding supervision of School Nurses is monitored to ensure that cases which have been on a child protection plan for over a year are discussed.

**Recommendation 13**

W&M LSCB to consider reviewing supervision arrangements by way of a multi-agency audit on cases involving child sexual abuse.

**Recommendation 14**

W&M LSCB to consider providing a programme of multi-agency specialist child protection training focussing on sibling abuse, interfamilial abuse in Black, Asian, and Minority Ethnic communities.

**Recommendation 15**

W&M LSCB is assured that interpreters employed by Children's Social Care in child protection cases have received sufficient training to maintain awareness of and adherence to the importance of impartiality, confidentiality and transparency when using interpreting skills in these circumstances.

**Recommendation 16**

W&M LSCB to facilitate Learning Events for Practitioners, on completion of the Serious Case Review, to ensure that lessons from the review are disseminated.

## SUMMARY OF RECOMMENDATIONS

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