Somerset Safeguarding Children Board

SERIOUS CASE REVIEW

In respect of:

Family 'A'
(Sexual abuse and neglect of three children)

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1. Reason for the Review

1.1 The subjects of this review are three children who have suffered significant harm as a consequence of chronic neglect and sexual abuse. There are records of neglect from Children's Social Care, schools, police and health agencies that span the last 15 years since referrals were first made to Children's Social Care in 2003. The formal investigation of allegations of sexual abuse is more recent and began with a disclosure by the oldest child in 2017.

1.2 Care proceedings in 2017 resulted in Supervision Orders being made in respect of the youngest and middle children.

1.3 The impact of abuse on the children will be considered thematically. The review will consider the physical and emotional impact of living with neglect, and the cumulative impact of poor and neglectful parenting.

1.4 The investigation of sexual abuse is a key theme and will also be analysed as part of this review.

1.5 The review will consider the response from all the agencies who knew the family, collectively and individually.

2. The Review Process

2.1 The Chair of Somerset Safeguarding Children Board initiated this Serious Case Review at the conclusion of a multi-agency practice review held in 2017. The information shared at the practice review indicated that the threshold for a Serious Case Review as defined in section 4 of Working Together 2015 had been met.[1]

2.2 The Serious Case Review process commenced in August 2017; terms of reference were agreed, and management reports requested from the following agencies:

Somerset County Council (Children's Social Care)
Avon and Somerset Constabulary
Somerset County Council, Legal Services
Somerset Clinical Commissioning Group
Youth Offending Team
Somerset Housing Association
Somerset County Council (Education Welfare Service)
Primary school

[1] Working Together 2015 p75

Secondary schools x 4
College of Further Education
Somerset Partnership NHS Foundation Trust
District Hospital NHS Foundation Trust
Somerset County Council (Getset Services)

2.3 Agencies were asked to review all relevant records relating to the children and the family from the first Child Protection Plan of Autumn 2012 until the granting of Supervision Orders in Spring 2017 (the older sibling moved out of the family home in spring 2016).

2.4 The learning and information from the multi-agency practice review meeting held in 2017 was also considered, along with the direct experience of numerous practitioners who had worked with family members.

2.5 One of the children agreed to speak to the lead reviewer to discuss their perception of the help that was offered to them and their family. The focus of this conversation was their experience of professional support and included positive experiences as well as negative ones.

2.6 The report author is Mark Dalton, an independent social worker with experience in conducting Serious Case Reviews.

Anonymisation

2.7 The subjects of this review are potentially identifiable from descriptions of their circumstances; therefore, this review will seek to protect their identities by referring to them by their place in the family.

2.8 Specific information which would identify individual family members will be limited in this report to enable its full publication. To protect the children's identities, specific incidents will not be discussed but presented as themes.

The Parents

2.9 The parents are a married couple, both local to the area. The extended family of one of the parents lived close by and they were occasionally involved in the care of the children. The mother was recognised as the dominant partner in the relationship and the one with whom professionals had the most contact. The mother had often been hostile and aggressive towards professionals and did not want any interference in how she chose to raise her children.

2.10 The husband has a more passive personality; for most of the period considered by this review he was in full time employment working long hours, which meant he inevitably had less contact with professionals. All the professional contact with him indicated that he shared his wife's view of professional involvement but would often take the line of least resistance rather than direct confrontation.

2.11 There is a history of all family members becoming involved in anti-social incidents in their community, sometimes resulting in altercations with neighbours and damage to property.

2.12 Both parents were psychologically assessed as part of the Care Proceedings and the assessment concluded that the parents were unable to make and sustain positive change, irrespective of support offered to them over a period of fourteen years.

2.13 The family had been the subject of multi-agency concerns for over ten years before the period under review. They have struggled as parents in meeting the needs of their children at all ages.

2.14 Any professional assessment should be cautious about labelling parents as "difficult", "hostile" or "hard to help". This report will highlight the failure to understand the children's perspective and their lived experience. However, it can be equally said that there was no professional perspective of the parents' views and the reasons for their resentment and rejection of professional involvement.

3. Defining Neglect and Sexual Abuse

Understanding Neglect

3.1 There are frequently problems for agencies in identifying and defining neglect where it exists alongside other forms of abuse. By itself, neglect comprises acts of omission and commission and the issue may be further complicated as a parent may be doing all they possibly can to provide safe and consistent parenting but are still seen as neglectful if the care is not of a sufficient standard.

3.2 *Working Together to Safeguard Children* (2015) defines neglect as follows:

Neglect: *The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:*

- *provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
- *protect a child from physical and emotional harm or danger;*
- *ensure adequate supervision (including the use of inadequate care-givers); or*
- *ensure access to appropriate medical care or treatment.*

3.3 It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

3.4 The analysis of neglect used in this review is based upon the framework used in "*Missed opportunities: indicators of neglect – what is ignored, why, and what is to be done*", published in November 2014.[2] This report recognises that it can be difficult to recognise the indicators of neglect and when the threshold for proactive action has been reached. The report argues for making decisions based on the observable impact on the child being neglected. Professionals also need to recognise the long-term consequences for children of living in a neglectful environment.

3.5 A recent (2018) joint report by Ofsted, the Care Quality Commission and the police and probation inspectorates[3] considered findings from joint targeted inspections of multi-agency responses to older children who are experiencing neglect, and notes that neglect of older children can go "unseen" and this group "may also be skilled at hiding the impact of neglect". Neglect may present differently in older children and agencies may respond to the symptoms of neglect rather than the cause.

Sexual Abuse

3.6 **Sexual abuse** is defined as *forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence,*

[2] Missed Opportunities: indicators of neglect – what is ignored, why, and what can be done? Brandon et al, DfE 2014
[3] Growing up neglected: a multi-agency response to older children Ofsted, CQC et al, July 2018

whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.[4]

3.7 The final sentence of the statutory definition is of particular relevance in this case because one of the disclosures of sexual abuse in the family was a disclosure of sexual relationship between a male child and an adult female (this concept was first introduced into *Working Together* in 2010). This abuse occurred when the child was still below the legal age of consent and therefore should have been investigated as sexual abuse.

4. Learning from the case

The Long-term Impact of Chronic Neglect

4.1 Neglect is the most common form of child maltreatment in the UK, it is also the most difficult for professionals to effectively engage with and produce long-lasting and sustained change in the family environment. In this case, the impact of neglect was evident in the physical standards in the home, anti-social behaviour in the community, poor school attendance, behavioural issues when the children were in school, failed healthcare appointments, and exposure to sexual abuse, parental violence and parental drug taking.

4.2 Neglect is a social construct: "clinical" neglect does not exist; for diagnostic purposes neglect is more helpfully considered as existing as a syndrome, where it is defined as a condition characterised by a set of associated symptoms. There are clusters of behaviours, patterns of interaction and presentations which are strong indicators that children have suffered parental neglect.

4.3 There are several assessment tools in common use in social work and health settings to help quantify the extent and impact of neglect.[5] With this family, it would seem that the parents' own problems and the fraught relationship with

[4] Working Together to Safeguard Children 2015 p93

[5] Examples include the Graded Care Profile and versions of the Neglect Identification and Management Tool.

professionals dominated the interactions between the family and agencies trying to work with them.

4.4 Chronic neglect can be more damaging than other forms of maltreatment because its impact is the most far-reaching and difficult to overcome. Neglect in the early years will also have consequences for later mental health and social functioning of the individual. The interpersonal and social problems demonstrated by the children may all be consequences of the psychological impact of neglect.

4.5 Given the history with this family, it is appropriate to question whether relative standards were also applied, and professionals tolerated a higher level of neglect of these children because of having low expectations of the parents.

4.6 In evaluating the information provided to this review there was a great deal of tangible and demonstrable evidence of the impact of parental neglect on the health and behaviour of the children. Parental attitudes towards professionals may partially account for the lack of a coordinated response but this was primarily the result of poor planning, a lack of analysis and a failure to coordinate interventions with the family.

4.7 The indicators of neglect were apparent to all professionals in this case and measurable evidence was available that the neglect experienced by the children was causing significant harm to their health, education and social development. This threshold was met in the Care Proceedings in spring 2017, although the evidence provided by the management reviews is that this threshold had already been met at the Child Protection Case Conference in 2012 and may well have been met much earlier.

4.8 It should not be forgotten that neglect can also be investigated as a crime, although this is a relatively unusual response and seen as a last resort. Given the lack of progress and serious nature of some of the incidents and because of the cumulative impact of neglect on the children, treating it as a criminal offence should have been considered in this case.

Vulnerabilities of children with additional needs

4.9 The youngest child has a diagnosed learning need and attended a Special School from Year 6. The observations and records kept by the school are the best indicator of the lack of progress in addressing issues of neglect and sexualised behaviour. As a result of the youngest child's intellectual limitations,

they required consistent parental oversight to keep them safe. Despite several agreements and undertakings by the parents that they would comply with safety plans there was no noticeable improvement in the youngest child's presentation or behaviour.

4.10 Research shows that children with disabilities are up to six times more likely to be abused than other children[6]. The reasons for this may include a reluctance to believe the disabled child, minimisation of the impact of the abuse on the child; or mistakenly attributing indicators of abuse to a child's impairment. Additional factors such as the disabled child's inability to resist abuse or ask for help are also important.

4.11 The youngest child in this family had behaved in ways which were strongly indicative of exposure to sexually abusive behaviour. An allegation of extra familial sexual abuse was investigated in 2012. The Police liaised with the school and obtained relevant information about the youngest child's level of functioning, which assisted them in preparing for a video interview. However, the mother would not give permission for her child to be interviewed. A further disclosure of alleged sexual abuse by an adult male was reported by the mother in 2013, who described that her child had an inappropriate interest in sex. The information was shared with Children's Social Care, but this allegation was never investigated. This was an oversight and has subsequently been addressed by the Police.

4.12 There are two clear issues in this case: firstly, the lack of thorough investigation when allegations of sexual abuse were made; these seem to be the result of the parents refusing consent for the youngest child to be interviewed. Secondly, there is the accumulation of evidence strongly indicating that the youngest child had been either sexually abused, exposed to inappropriate sexual material or witnessed sexual abuse as a third party. The concerns from the primary school, Police intelligence reports and direct experience from the professionals involved with the family needed to be brought together through a Section 47 strategy discussion. In this instance, despite the multi-professional concerns, a Strategy Discussion was not initiated.

Safeguarding in Schools

4.13 This review has raised a number of concerns about safeguarding practice in several of the schools attended by children. It is clear that schools were aware of the issues of neglect and the home life of the children. There are concerns about how these were recorded and monitored and how these concerns were addressed and escalated to Children's Social Care. For example, one of

[6] 'We have the right to be safe' Protecting disabled children from abuse NSPCC 2014 p8

the primary schools kept daily notes on the youngest child for a period of four years. The entries are unsigned but describe concerning sexualised behaviour and neglect and include a sexually explicit drawing by the youngest child. This drawing alone should have been referred to Children's Social Care. The reports written by the school for core groups and Child Protection Conferences did not include the details they had recorded on a daily basis.

4.14 The safeguarding arrangements at the primary school were not compliant with statutory guidance. The role of Designated Safeguarding Lead was held by an administrator and not a senior member of the school. This is contrary to *Keeping Children Safe* regulations.[7] This case is a very good example why the Designated Safeguarding Lead needs a background in education and child development and has the authority to challenge other agencies and escalate concerns.

4.15 Schools and education services such as Parent/Family Support Advisers (PFSA) and the Education Welfare Service (EWS) had important roles in contributing to the assessment of risk and addressing the concerns about these children. Through the course of this review it has become apparent that there are differences between what schools had reported to Children's Social Care and what they recorded on a day to day basis.

4.16 The Parent/Family Support Advisor (PFSA) was involved with the family for three years. Given the nature of the long-standing concerns and the fact that the children were subject of Child Protection Plans for a significant time during this period, the lack of formal recordkeeping is a cause for concern. The PFSA attended some safeguarding meetings, including Child Protection Conferences, but should also have kept case records of their ongoing involvement.

4.17 Many of the communications (emails and phone calls) sent by schools and the EWS did not appear in the Children's Social Care chronology. The emails were often just reporting concerns to the social worker, but with no subsequent follow up or agreement as to how quickly this would happen. This failure contributed to the case drifting. Despite the frustration by the schools and EWS that the case was at times without an allocated social worker or any formal review of the case, no formal complaint or escalation was recorded.

4.18 There are some positive examples of safeguarding practice and diversion within the schools attended by these children, in particular the oldest child's

[7] Keeping Children Safe in Education. Statutory Guidance for Schools and Colleges p59. Revised guidance has been issued and will commence on 3rd September 2018 the role of the designated safeguarding lead is explained on page 18 of the new guidance.

secondary school and college offered additional support and access to counselling. The middle child also reported a more positive experience of their second secondary school because bullying was effectively dealt with and they felt safe.

4.19 Confronting parents who could be intimidating and aggressive was acknowledged as a risk by some schools. Failure to challenge the parents may also have reduced still further the children's attendance. The primary and special schools chose to support the children's attendance by providing changes of clothes and toiletries to address some of the issues arising from the neglect of the children's basic needs. The schools have also noted that the level of attendance would have been significantly lower if they had not also assisted in getting the children to school in the morning.

School Attendance

4.20 Poor school attendance was a long-standing issue for all the children. The primary schools and the Education Welfare Service had attempted to engage the parents to improve school attendance but none of these efforts had been successful.

4.21 The first prosecution for school non-attendance in relation to the older child occurred just after they had commenced secondary school. Due to the on-going poor attendance the local authority had obtained an Education Supervision Order in respect of the middle child two years later. The middle child attributes some of their poor attendance as being the result of bullying, which they believe was not addressed by the school. The Education Supervision Order was discharged, because it was having no impact on attendance.

4.22 A second prosecution for the same issue in respect of both the middle and youngest children was made 18 months after the discharge of the Education Supervision Order. The parents pleaded guilty and were given Community Sentences. The Probation Report noted that the mother felt unable to cope with the middle child and that the younger child's poor attendance was due to medical issues. The father felt unable to help in getting the children to school because he had to work

4.23 Poor attendance by both the younger children continued to be an issue and, 6 months later the parents were prosecuted and fined a third and final time.

4.24 The parents were prosecuted three times for the non-attendance of their children at school over a four-year period. Prosecuting the parents had no

effect on the level of attendance and did little other than demonstrate the impotence of the statutory services and leave the parents to blame their children for the problem.

Failure to engage the family

4.25 Both parents, but particularly the mother, presented as hostile, evasive and resentful of attempts by professionals to intervene on behalf of the children. The children's mother had her own health problems which impacted on her ability to parent the children.

4.26 The father avoided professional contact as far as possible and did not seem to professionals to play a proactive role in parenting the children. On the occasions he met with professionals he appeared conciliatory and cooperative but was not motivated to work with them.

4.27 The collective professional experience of working with the family is that they resented outside involvement, at best tolerated this and at worst were aggressive and obstructive. The level of this sustained hostility is outside the normal range of experience for most workers. At different times, attempts were made to effectively engage the cooperation of the parents with the provision of material support; however, this did not produce any sustained improvements in the quality of the relationship.

4.28 The ability of professionals from Children's Social Care to establish effective working relationships with the children and their parents appears to have been hindered due to the number of different workers involved with the family. Whilst it is inevitable that professionals will move on from time to time, for part of the period under review Somerset was having a particular problem recruiting permanent members of social work staff. Between 2012 and 2015, the management of the children's case was overseen by 9 different team managers and 6 allocated social workers. It is quite likely that some of the inertia evident in this case can be attributed to the case being allocated to short-term locum social workers who were not in post long enough to build a working relationship with the children or their parents. It is notable that some of the schools – where staffing was more stable – felt they were able to build productive relationships with the older children and were able to have a positive impact on their behaviour.

4.29 Children's Social Care were not the only agency which experienced significant changes of staff. The Education Welfare Service also had 5 education attendance/welfare officers and 5 managers allocated to the case during the period under review. In addition, the EWS restructured, which may

also have contributed to: (a) the relevant information about the case not being available to the allocated workers or (b) the information having been made available but not being pursued effectively.

4.30 Further, numerous referrals were made to different agencies attempting to work with individual children with a limited role. Given the family's antipathy to accepting help this made it relatively easy for them to avoid appointments and manipulate the network of professionals, particularly when the case was reallocated to a new worker.

4.31 Workers have felt compromised between doing their best to maintain a working relationship with the parents, which at least allows them some access to the children, and challenging the quality of parenting, which almost inevitably led to confrontation and access to the children being denied. In terms of learned experience, the parents have "learned" that professionals will eventually back down, and whatever consequences are threatened, ultimately nothing changes.

Concern about missed opportunities and drift

4.32 Arguably, the key moment in the period under review was the failure to follow through on the recommendation from the Initial Child Protection Conference in autumn 2012 to initiate legal proceedings if the Child Protection Plan failed. At this point, Children's Social Care and other agencies already had ample experience of seeking to engage the parents (given that concerns were first raised nearly a decade earlier), and it is in the light of this previous negative experience that the decision was taken to seek a legal remedy after a relatively short time.

4.33 The fact that the plan was only given a month is instructive; given what is known about the nature and causes of neglect, and the difficulty in changing parental behaviour, the decision to give the family one month to demonstrate a commitment to change suggests firstly, that agencies recognised the seriousness of the situation and secondly, they were not prepared to give the family time to obfuscate and delay.

4.34 However, despite these good intentions, there was a failure to act on the Child Protection Contingency Plan, which cannot be explained away by changes in personnel or through a lack of supervision. Fundamentally, all agencies would appear to have failed in their responsibilities to effectively safeguard and protect these children.

4.35 The second significant missed opportunity was the decision not to seek Care Orders when proceedings were before the Court; when the children had reached adolescence. It is a cause for concern that the local authority continued with its plan for Supervision Orders against the advice of all other agencies, including the Chair of the Child Protection Conference and the CAFCASS Children's Guardian. There were also statements from the Court which indicated that the Judge had reservations about this plan and gave the local authority every opportunity to reconsider. Ultimately, the Court, as the final arbiter in the decision-making process, was assured that the plan presented by Children's Social Care was of a sufficiently robust nature to meet the needs of the children.

4.36 Regardless of how "robust" a plan is, it is only effective if it is followed and implemented as agreed. Unfortunately, in this case the agreed plan was not adhered to by the family, but this did not result in any further action from Children's Social Care to take steps to safeguard the children.

4.37 There are practical difficulties in removing older children, where there is a strong bond with their parent and an understandable fear and anxiety about being compelled to live elsewhere. It was clear that the middle sibling did not want to leave their parents and this view had to be considered. Furthermore, there would have been the distinct possibility that they would "vote with their feet" and run away from any placement. [8]

4.38 The same argument could not be made for their younger sibling who had a significant developmental delay and other health problems. The local authority reported to the Court that they had difficulty identifying an appropriate placement for a planned move and could not find anywhere suitable.

4.39 Identifying a suitable placement for children with challenging behaviour and specific needs is extremely difficult (as has partially been demonstrated by the failure of the respite care arrangements for the youngest sibling). However, as the case was before the Court, Children's Social Care should also have considered the potential harm of making an unplanned placement, which would have resulted if the Judge had been swayed by the argument of the Children's Guardian and made a Care Order.

[8] "Professionals across all agencies must challenge any notion of older children being described as 'choosing a lifestyle'. They must challenge the idea that because a child appears resilient this means they do not need help. …. choices older neglected children appear to be making are often their way of trying to cope in an unsafe world but in fact put them at more risk. " Growing up neglected: a multi-agency response to older children. P29

Failure to use procedures

a) Child Protection Plan

4.36 The rationale for ending the Child Protection Plan, despite the evidence that circumstances at home had not improved, is unclear - it is described as a "unanimous" decision, but given the disquiet from School, School Nursing and Health and the demonstrable lack of progress, it is hard to understand why they would have agreed to this course of action. The social worker's supervision record from earlier that year also states that "the CP plan has been in place for almost 2½ years with little change to the lives of the children".

4.37 However, the GP notes recorded:

> *"Somerset County Council Children's Services Conference Record....'it was a unanimous view of this conference that [the children] should no longer be subjects of a Child Protection Plan. But they will continue to be supported as Children in Need as the above plan still needs to be progressed & monitored".*

While the decision seems to have been recorded as "unanimous", this is incorrect and the school and PFSA are clear that they did not agree with this decision.

4.38 This was clearly an overoptimistic decision apparently, based on assurances from the parents that they would work with professionals under Child in Need arrangements. It is unfortunately a common error in neglect cases to focus on arrangements with parents and overlook the everyday experiences of the children.

4.39 At this time, the Signs of Safety approach had been recently introduced into Somerset and was used in Child Protection Conferences to give clear, concrete examples of changes which needed to occur in order to reduce risk. The principle of Signs of Safety is that it uses everyday language with practical examples of what needs to change. The current level of risk is then given a score out of ten, with examples of what would need to change to improve that score. Despite its simplicity, Signs of Safety is a subtle tool and only works effectively if it begins with an honest multi-agency appraisal of current difficulties. This does not appear to have happened in this case.

b) Legal Process

4.40 Some of the legal decisions in this case were made before the current process known as the Public Law Outline was in place. The Public Law Outline was applicable for decisions from summer 2014 onwards, but prior to that there was

still a system in place for consulting on legal decisions which would have considered historical concerns.

4.41 The lack of transparency regarding the legal decision making is a matter of concern: firstly, not convening a legal planning meeting following the failure to implement the contingency plan agreed at the Initial Child Protection Conference; secondly, the in-house "legal planning meeting" held without any professional legal advice.

4.42 By the time these proceedings were before the Court, Children's Social Care faced a dilemma of where to place two adolescent siblings with a high level of need, who clearly stated that they wished to remain with their parents. It proved impossible to find suitable carers close enough to enable links with school and family to be maintained.

4.43 Therefore, the task was to balance the potentially negative impact of moving out of area and disrupting family links against the potential benefits of providing the experience of a secure foster placement. Children's Social Care would also have been conscious that children in care do not always thrive and there are well-known risks in placing adolescent children against their wishes. There is no evidence that the local authority explained its dilemma to partner agencies which led to further frustration and breakdown in the professional relationships.

4.44 It would seem that Children's Social Care was the only agency who believed that leaving the children at home was the best course of action. It is a common response when cases of neglect finally come before the Court that collectively everyone wishes that their predecessors had commenced proceedings earlier.

4.45 The view of the Children's' Guardian was that Care Orders were the only option which safeguarded the children, gave them some hope of addressing the physical and psychological damage they had suffered, and enabled them to take advantage of school and education. The Children's Guardian reluctantly supported the local authority's plan as there were no identified carers.

4.46 Disagreement over the decision not to seek Care Orders has been an important feature of this review. It would be wrong to portray the disagreement as an argument between the relative merits of Care Orders versus Supervision Orders. The original intention of the local authority was to apply for Care Orders and place the children with parents under the Placement with Parents Regulations.[9] The local authority's argument was that Care Orders gave them parental responsibility and sufficient authority to override parental objections

[9] In exceptional circumstances the law allows for a Child subject of a Care Order to be placed with their parents – see Placement of a Child in Care with Parents

about the care of the children. By the final day of the Court Hearing the local authority had also identified a respite carer for the youngest child who would look after them every weekend.

4.47 The Care Proceedings were subject to numerous delays, some of which were the result of the parents' refusal to engage in the process. Given their track record and previous relationships with the local authority, this was to be expected. However, significant delay was also caused by the local authority's lack of organisation and failure to complete tasks to agreed timescales. There are numerous examples of this, such as the failure of Adult Social Care to allocate the request for a Carer Assessment on the parents until a fortnight before it was scheduled to be filed. Children's Social Care also failed to file reports on time and equivocated in the decision whether to seek Care Orders or Supervision Orders in respect of the children.

4.48 As part of the Court proceedings, a schedule of expectations specifying the actions the parents must take to support the plan was drawn up by Children's Social Care. This document forms a contract between parents and Children's Social Care and explicitly states, in unambiguous detail, actions the parent should undertake to improve the health and school attendance of their two youngest children. The schedule of expectations was originally agreed and revised to take into account changed circumstances when Supervision Orders were finally granted. The schedule of expectations was not legally binding, but the Court would consider failure to comply as evidence in further proceedings.

4.49 Unfortunately, the schedule of expectations proved to be ineffective and did not lead to the hoped-for changes in the parents' behaviour. It could be argued that the failure to follow through the plan and return to Court if the parents failed to comply has been additionally counter-productive because it had demonstrated the local authority's unwillingness to confront the parents' lack of cooperation.

Listening to the Children

4.50 The voice of the child is an important concept in child protection as well as all other areas of social work with children.[10] There is a balance to be struck

[10] Ofsted (2011) The voice of the Child: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1st April to 30th September 2010. This report noted that the children were only able to speak about their experiences once they had been removed from their home environment. Ofsted claimed that this underlined the importance of providing a safe and trusting environment, away from carers, for children to be able to speak about concerns.

between respecting the wishes of the child and protecting them from the possibility of future harm where the child chooses an unsafe or dangerous environment.

4.51 The child of the family who contributed to this review stated that they felt that the social workers were there for her parents and did not remember any one to one conversations with social workers when they visited the home. They also remembered that the social workers changed without explanation or saying goodbye. At risk of stating the obvious, these simple steps of proper introductions, handover and farewell show respect and courtesy and may also lead to building a working relationship with a child.

4.52 In this case, despite long-standing professional concerns about the quality of parenting and dangers within the home, the children, when given the choice, unsurprisingly opted for remaining at home. This was to be expected, but nonetheless did not negate the professional responsibility to explore alternative care and the conclusions could have been different for each child. It should be noted that the Children's Guardian discussed the prospect of foster care with both children and believed that, with the right introduction, the younger child was open to the idea and it could have been explored further if the local authority had been able to identify suitable carers.

4.53 A further practice issue is raised by the response to the male child's disclosure of his sexual abuse by an adult female. Following the initial enquiries with the family and the identification of the likely suspect, the decision was taken not to proceed with this as a criminal investigation despite a clear allegation that a sexual offence against a child had been committed. Given the strength of the evidence, the decision not to investigate further is unusual and contrary to Police guidance. The decision poses the question about whether there was an unconscious bias because the victim was a male and the perpetrator an adult female, or whether the identity and history of the victim played a part in the decision not to take further action.[11]

Resolving professional differences

4.54 On several occasions there was significant disagreement in the professional network; the failure to seek legal advice following the lack of progress of the Child Protection Plan, the decision to seek revocation of the Education Supervision Order and the lack of strategy meetings following the disclosures of sexual abuse are examples where there was significant disagreement about the management of the case by Children's Social Care from other agencies.

[11] During 2017/18 Avon and Somerset Police have invested in training to raise awareness of conscious and unconscious bias. Equality Report 2017

4.55 The 'unanimous' decision that the Child Protection Plan should be ended because there was agreement that the aims had been achieved is questionable. It would have been the wrong decision to end the Child Protection Plan because it was ineffective, but at least this would have been an honest reflection of reality.

4.56 The Child Protection Conference Chair (hereafter referred to as the CP Chair) responsible for chairing the Initial Child Protection Conference and subsequent Review Child Protection Conference was in a position to challenge the analysis by Children's Social Care that the children should no longer be subject of Child Protection Plans. The CP Chair could also have challenged the conduct and effectiveness of partner agencies involved in the case.

4.57 The CP Chair has a statutory responsibility to raise concerns where children are placed at risk, and whilst concerns were raised these were not proactively followed up. This case raises concerns about the relative status of CP Chairs in relation to Team Managers, and whether their concerns are taken on board. It would appear that in this case the concerns of the CP Chair were too readily dismissed, and they were told they had no authority over "operational" decisions. However, it was the responsibility of the CP Chair to escalate their concerns and it is unclear why this did not occur.

4.58 Other agencies, in particular the school attended by the youngest child and the school nurse, seem to have become jaded by their experience of referring concerns to Children's Social Care, with no apparent effect. As discussed earlier, there is evidence that the school nurse sought to escalate her concerns through her line management; however, this did not materially affect how Children's Social Care managed the case.

4.59 The Somerset Safeguarding Children Board website includes a protocol for resolving professional differences[12] which could have been used formally to raise these concerns with Children's Social Care and if necessary escalate to senior management. This protocol was revised in late 2016 (it was previously known as the Escalation Process) and is clearer and more robust than the previous version.

4.60 There is an overall reluctance to use these procedures for a number of possible reasons; this is not a problem unique to Somerset and is a common finding of Serious Case Reviews. It may be that professionals are concerned about making an implied criticism of the professional standards of colleagues, fellow

[12] Resolving Professional Differences Protocol

feeling in working with a difficult and unrewarding case, an understanding of resource implications and fearing a negative non-productive outcome.

4.61 It should be reiterated that safeguarding is a multi-agency responsibility and expressing dissatisfaction in the management of the case by Children's Social Care is not an adequate professional response from any agency to the continued neglect of these children. *Working Together* (2015) and the *Children Act* (2004) place an equal duty on partner agencies to safeguard children and therefore agencies have a responsibility to escalate concerns until there is a satisfactory resolution.

Information Sharing and Professional Relationships

4.62 There were clearly problems in sharing information in this case that were not simply the issue of failure to recognise the significance of information and pass it on. At times it would seem there were so many ongoing concerns that repeated themselves so frequently that some agencies, such as the primary school, simply recorded information (much of which was very relevant in terms of evidence of neglect) but did not pass this on regularly to Children's Social Care or include it in statutory reviews and case conferences.

4.63 The lack of consistency within Children's Social Care is an important factor in this dynamic. There were times when there was no allocated Social Worker, or Core Group meetings and passing information to a duty officer would not have seemed useful as these were pre-existing concerns which were well known to Children's Social Care as an agency. It is also the case that some agencies were wary of an aggressive response from parents if they raised concerns with Children's Social Care.

4.64 In child protection, a key relationship is between Children's Social Care and the Police. The Police Management Report records regular sharing of information with Children's Social Care and several strategy discussions. However, the report also notes that passing on information without concerns being analysed does not lead to proactive safeguarding action. The Police also failed to escalate their concerns about the family and it would seem they failed to link separate callouts to the family home and build a picture of chronic neglect.

4.65 Experience has shown on countless occasions that there is no substitute for face-to-face discussion to share concerns and analyse risks. This is particularly true of intractable cases which need face-to-face interaction to overcome the tendency to accumulate information without analysing it.

4.66 The review has revealed some very specific information sharing issues within schools; however, it would be prudent to consider these lessons across all agencies. The initial recording of concerns needs to be in objective and

quantifiable language. All records need to be signed and dated, including the date they are shared with colleagues or other agencies. These reports need to be kept securely in the individual child's record and transferred between schools when the child moves. This applies equally to school records and those kept by other school-based services such as Parent/Family Support Advisors.

4.67 Contemporaneous records can be powerful evidence if they are recorded professionally. These concerns should also be reflected in case conference or other reports to provide an honest analysis of the level of risk.

4.68 Working with this family had a debilitating effect on the professional system; they displayed a high level of need and a high level of aggression simultaneously. Paradoxically, they would complain equally of a lack of support and of interference in their family. Professionals were wary of contacting the family with bad news and became used to being abused and intimidated. The failure to effect any change in the family with an apparent lack of consequence also led to some professionals behaving in a way where they were disempowered and deskilled.

4.69 There is no evidence in any of the reports of collaborative working to support colleagues who were being intimidated. In a case such as this one we would hope to see recommendations for joint visiting, support from managers and supervisors and discussions about strategies to reduce the risk to individual workers. Visiting the family at home in a relatively isolated rural community – sometimes outside office working hours and alone was an intimidating prospect. This needs to be recognised as difficult and challenging work and managers from all agencies have a responsibility to support their staff.

4.70 Early in the period under review, at the Initial Child Protection Conference, the Police representative noted that working with the family would require a strong team of professionals who were able to support each other and stick to agreed plans. It is possible that staffing problems within Children's Social Care created a decision-making vacuum, and consequently the agencies lost the focus on the need to exchange information effectively. This multi-agency approach should have been the modus operandi of the Core Group; as such it would be expected in the absence of an allocated social worker monthly meetings would have continued to be held and chaired by a representative of one of the other agencies involved with the children.

4.71 It is also apparent that some agencies which could potentially have played an important part in working with the family were not integrated into the professional network. The Housing Association appears to have had little engagement in the concerns about material standards in the home (until later on in the period under review when concerns centred on reducing the number of animals kept in the premises), but instead had a narrow focus on anti-social behaviour and rent arrears. Similarly, the Education Welfare Service seems to have been focused on attendance issues rather than underlying problems.

Exchange of information was sporadic with little evidence of inter-agency dialogue.

Sexual Abuse

4.72 Sexual abuse is a category of abuse in its own right and not always a symptom of neglect. It is an unusual feature of this case that the very obvious signs of sexual abuse were not more fully investigated by agencies. A more usual response is for concerns about sexual abuse to overwhelm other pre-existing concerns of neglect.

4.73 The youngest child had shown signs of sexually reactive behaviour and had possibly re-enacted their own experiences of being abused. Although they did not make a disclosure, they attempted to engage in sexual activity and initiated sexual contact with other adults and children.

4.74 The two older children discussed in this review have both made disclosures of sexual abuse that were not investigated at the time of the disclosure. The parents did not support further investigation; however, given the seriousness of the alleged crimes this should not have prevented an investigation taking place. There is no record of a Strategy Discussion or further action following an allegation of rape by one of the children.

4.75 The allegation of a sexual relationship between a twenty-five year old and one of the children led to a strategy discussion and a joint Police and Children's Social Care 'section 47' investigation. However, the investigation was not progressed and discontinued after two weeks because the family refused to engage with the Police.

4.76 The differing responses to the allegations of different types of sexual abuse is striking; the allegations made by one of the children of sexual abuse by an adult female, were not considered as a possible case of child sexual exploitation (although the circumstances of the case would have fitted with the Barnardo's model of child sexual exploitation in use at the time[13]). The challenge to all agencies is whether the potential for males to be victims of child sexual exploitation is recognised and responded to with equal seriousness as female victims.

4.77 It is significant that the oldest child did not disclose the sexual abuse by an uncle until they had moved out of the family home. Research shows that

[13] Working with children who are the victims or at risk of sexual exploitation p12. This report suggests different models of child sexual exploitation, one of which is the Boyfriend/girlfriend model where the child is groomed into a "relationship" and believes their abuser to be their boyfriend or girlfriend.

young people often need to feel safe before they disclose. The oldest child eventually disclosed to a worker from the Youth Offending Team in the context of work on healthy sexual relationships. The Youth Offending Team worker played a crucial role in supporting the oldest child in making a disclosure to the Police. This illustrates the need for emotional support for the victims of sexual abuse; in this case it was available because the child was already engaged in the service, and support may not have been so readily available if the child had not had this pre-existing relationship.

5. Findings

5.1 The unavoidable conclusion of this review is that the significant neglect experienced by these children should have been identified earlier and the local authority should have used its statutory powers to safeguard them and promote their welfare.

5.2 In addition, they have been the victims of sexual abuse which does not appear to have been properly investigated. Equally the therapeutic needs of the children were not assessed. It is too early to ascertain whether this level of maltreatment will have long-term impact into their adult years, but research would indicate that there is a strong possibility they will develop further mental health and social problems as they become older.[14]

5.3 Children's Social Care had a number of opportunities to intervene and safeguard the children. The failure to act decisively may be partially explained by staffing problems within Children's Social Care. However, Children's Social Care is not solely responsible for the apparent breakdown in interagency working; all agencies share this responsibility.

5.4 A further significant factor has been the implacable hostility of the parents to help from any agency, and their ability to keep professionals at arm's length.

5.5 The management reports from Police, Schools, Community Health, Education Welfare Service and the Independent Reviewing Service portray a consistent picture of failed parental engagement and no consistent evidence that the concerns about the children's welfare were being successfully addressed.

5.6 Schools and colleges attempted to address the obvious needs of the children on a day-to-day basis - sometimes providing food, or changes of clothing for the children where necessary and contacting the family directly to confront attendance issues.

5.7 The failure to address the safeguarding needs of these children was systemic and all agencies share some responsibility for the failure to act. While some

[14] Missed Opportunities: indicators of Neglect DfE 2014 p9.

concerns were passed on, the failure to improve the home conditions remained apparent and all agencies, therefore, had a duty to escalate their concerns within their own line management structure and the wider safeguarding system.

5.8 In summary, these issues were the same as those first noticed over a decade earlier, the manifestations of the problems had slightly altered as the children had grown up but remain fundamentally the same. The only change was in the process of growing up in a culture of Neglect; the cumulative impact on the children was that they became more difficult to work with as they mirrored their parents' antagonistic and anti-social behaviour; their vulnerability to sexual abuse and exploitation increased, and health and social problems became more evident.

Recommendations

1. Somerset Safeguarding Children Board should develop a comprehensive training programme on identifying and working with Neglect and make this available on a multi-agency basis to all frontline practitioners and their managers.

2. Somerset Safeguarding Children Board should review the response to the recognition and response to sexual abuse from all agencies. The Police and Children's Social Care should ensure that their practice regarding the investigation is compliant with the South West Child Protection Procedures.[15]

3. Frontline practitioners working with children and families from all agencies should be trained to work with families who display aggressive and evasive behaviour.

4. Somerset Safeguarding Children Board should seek assurance that Child Protection Chairs are sufficiently supported to fulfil their statutory responsibilities including challenge to all agencies when Child Protection Plans fail to protect children; and that appropriate measures are in place to document where challenges have arisen such that these can be monitored and reported to the SSCB.

5. Somerset Safeguarding Children Board should ensure that Child Protection Plans are routinely and effectively audited to confirm that they address the risks identified.

[15] Child Sexual Abuse in the Family Environment

6. Somerset Safeguarding Children Board should seek assurance that all schools are compliant with the legal requirement that the Designated Safeguarding Lead in every school is a senior member of the teaching staff.

7. The Resolving Professional Differences Protocol should be relaunched and embedded across all partner agencies.

8. Child protection supervision for all cases where children are the subjects of Child Protection Plans or Child in Need plans must be a priority for all agencies.

9. The inability to resource Child Protection Plans, either through lack of staff or other resources, should be escalated within agencies' own line management structures or through use of the Resolving Professional Differences Protocol.

10. Parent/Family Support Advisers should keep professional records of their involvement with families. Schools should include information from these records in reports to Child Protection Case Conferences and share information with other agencies.