Gloucestershire Safeguarding Children Board

Serious Case Reviews

Executive Summary

0105

Mrs Spry

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Gloucestershire's Children and Young People's
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Introduction

1.1 This Serious Case Review was commissioned by the Gloucestershire Safeguarding Children Board (GSCB) to focus on the care given to 5 children who were placed in the care of a single carer, Mrs Eunice Spry, and who were either privately fostered, fostered through the local authority or adopted by her, or were made subject to Residence Orders whilst in her care. The period of care spanned 20 years, from when the first child was privately fostered in 1984, through to December 2004, when two of the children had left home as young adults and allegations were made that throughout their lives with Mrs Spry, all the children had been physically and emotionally abused by her. Child protection investigations were undertaken, at which time the children/young people disclosed a significant level of serious abuse, including the sexual abuse of one child, which led to the remaining two children in Mrs Spry's care being removed and placed into Local Authority care.

1.2 This Serious Case Review was therefore commissioned because of concerns that the children had been subjected to abuse, which was undiscovered for a number of years, and that during this time Mrs Spry had been formally approved as either their carer or as their adoptive parent.

1.3 As part of Gloucestershire Safeguarding Children Board's (GSCB) commitment to learn and develop interagency child protection practice within Gloucestershire, and in accordance with "Working Together" guidance from the DCSF a Serious Case Review was undertaken to establish the facts of the case, to analyse the professional interventions with these children and to identify how the different agencies in Gloucestershire can work together better to safeguard children and young people.

1.4 In particular the Review was established to address: -

- How and why the children came to be cared for by Mrs Spry
- The processes by which Mrs Spry was approved to care for these children
- Information about the children's health and well-being whilst in the care of Mrs Spry.
- Any contact between agencies regarding the care of these children and any action taken following this contact.

1.5 The review, as outlined above in 1.4 above, was completed and the resulting Overview Report and it's recommendations were signed off by the GSCB September 2006 however, Mrs Spry's trial in February/March 2007 brought to light important information that had not been considered during the review process. Therefore, the GSCB commissioned an addendum to the Overview Report (see point 5 below for explanation of the term) to: -

- Address the issues raised by this information
- Consider why it was not available to be considered as part of the main Serious Case review.
- Make recommendations as appropriate to reflect the consideration and analysis of this new information.
- Make recommendations to support the sharing of such information in the future.

The first Executive Summary, published in April 2007, set out the position following the first Overview Report and explained the need for an addendum to the report. This Executive Summary summarises the whole of the Serious Case Review including information from the addendum to the Overview report.

Case Review Process

2.1 Serious Case Reviews are undertaken as standard practice whenever an incident of serious harm to children occurs and where there may be public interest.

2.2 Serious Case Reviews require each agency that had some direct involvement with an identified child/children and their carers to undertake an Individual Management Review (IMR) that looks openly and critically at individual and organisational practice with them. Each agency is required to produce a chronology of its contact with the children and their carer. Managers conducting the Individual Management Reviews (IMRs) must not be directly concerned with the services provided for the children or carers, or the immediate line manager of the practitioners involved.

2.3 Members of a Serious Case Review Sub Committee bring together the information provided from the Individual Management Reviews and then consider the professional practice and inter agency working as it relates to the subjects of the review. Members of this Serious Case Review Sub-Committee in Gloucestershire are senior experienced professionals from Gloucestershire Children and Young Person's Directorate (CYPD) (covering social care and education services), the NHS, (including Primary Care Trust, Gloucestershire Hospitals Trust and Gloucestershire Partnership Trust), the Probation Service, Gloucestershire Constabulary and the NSPCC.

2.4 The Serious Case Review Sub-Committee must then commission an independent person, as laid down in 'Working Together' to bring together the Individual Management Reviews and produce an Overview Report.

2.5 In this particular Serious Case Review the Serious Case Review Sub-Committee commissioned an independent person with extensive experience in the field of child protection to write the overview report from which this Executive Summary has been produced.

Case Details

For the purposes of confidentiality, different names have been used in this report to represent the 5 children/young people.

Anne	**Born in 1984**
Belinda	**Born in 1986**
Carol	**Born in 1985**
David	**Born in 1988**
Edward	**Born in 1992**

3.1 The four of the five children/young people who are the subject of this review were all placed with Mrs Spry as a result of private arrangements between Mrs Spry and their natural parents (private fostering).

3.2 Mrs Spry privately fostered the eldest child, Anne, from 1984. The second Belinda was placed with Mrs Spry by the local authority just over two years later. Mrs Spry subsequently adopted Anne in 1989 (5 years old) and Belinda in 1992 (6 years old). Mrs Spry had two older daughters of her own, who were young adults by the time Anne and Belinda were fostered. The eldest of these daughters remained living at home and helped her mother to care for the younger children in the household.

3.3 By mid 1993 the other three children, Carol, David and Edward, all siblings from another family, had been made subject of Residence Orders, granted to Mrs Spry. Prior to this time Mrs Spry had privately fostered the children by private arrangement with their parents.

3.4 Mrs Spry's contact with Gloucestershire Social Services began in 1979 when she applied to become a childminder. This application was initially declined because of unspecified concerns from the health authority but these concerns were subsequently lifted and approval was granted. Mrs Spry's first application to become a foster parent in 1983/4 was declined because she was a Jehovah's Witness and it was felt that this lifestyle would not accommodate being a foster parent. These objections were removed and she was approved as a local authority foster carer from 1885 until 1994.

3.5 By the end of 1993, Mrs Spry had legal parental responsibility for all five children, through Residence Orders or Adoption Orders made by the court. Involvement of Social Services in the care of the children ceased at this point.

3.6 By November 1994, the five children had been removed from school by Mrs Spry and educated at home by her and her eldest daughter. Between October 1990 and 2000, concerns about the care of the children were expressed on 12 occasions. Social Services did respond to these concerns but these responses did not lead to continued social work involvement. Mrs Spry was described as "eccentric" and there was evidence of her being quite controlling and being difficult to engage in professional interventions. Her frequent moves of home added to the difficulties.

3.7 Mrs Spry brought all five children to the attention of medical professionals for a range of physical and emotional/behavioural difficulties. This continued throughout the time she cared for them. At one time at least three of the children were prescribed Ritalin and Mrs Spry made separate claims that the four youngest children suffered with significant behavioural and developmental problems.

3.8 In September 2000, the family were involved in a serious road traffic accident in which Anne, then aged 16 years, and Mrs Spry's eldest daughter (aged 37 years), were killed. Belinda (aged 14 years at the time) received multiple injuries and although she used a wheelchair for a period of four years, she was able to become mobile once she left Mrs Spry's home when aged 18 years. Edward was also injured in the car accident with a broken femur.

3.9 In December 2004 when Belinda left home as a young adult, she made allegations that she and the other children had been consistently physically and emotionally abused by Mrs Spry, by being beaten with implements or punched, locked in their bedrooms and starved of food. Belinda also complained that Mrs Spry had forced her to remain as a wheelchair user. Carol, who was 19 years and who had also left the home by this time, was approached by police and social services and made very similar allegations. David and Edward were still in the care of Mrs Spry, and when they were interviewed, they corroborated much of what was alleged by Belinda and Carol. David also later claimed that he had been sexually abused.

Key Findings

The process by which Mrs Spry came to care for the 5 children

4.1 In respect of the separate adoptions of Anne and Belinda, the files indicated that there was much debate by health and social care professionals about the suitability of Mrs Spry for the role, and the fact that Belinda's adoption was deferred for a period of over 3 years, reflected this. It was apparent that the length of time that Mrs Spry had already been caring for the children (approximately 4 yrs 8 months and 5 yrs 3 months respectively), the need for them to have legal security and the potential for distress if the children were to be moved, meant that the adoptions were granted in Mrs Spry's favour.

4.2 There are no specific concerns recorded in respect of Anne's care at the time of her adoption in April '89, but at about the same time concerns were beginning to emerge regarding Mrs Spry's care of Belinda with evidence of Mrs Spry's "lack of emotional warmth" towards her. Referrals

were made to social services concerning her over-punishment of Belinda, including expressions of concern from her Head Teacher about Mrs Spry's harsh approach to Belinda.

4.3 In December 1991 the Social Services Team Manager informed Mrs Spry that she would not be supporting Belinda's adoption because of concerns she held about Mrs Spry's care of her and instigated a six-month intensive assessment of Belinda's care. It is concerning that this assessment was not completed (Mrs Spry refused to see the social worker) and the adoption was confirmed through the Court, less than a month later, without these recent concerns being addressed. The review has not been able to establish how the court made an adoption order in these circumstances.

4.4 At this time another two children (Carol and David) began to be cared for by Mrs Spry within a private fostering arrangement.

4.5 At the same time, Mrs Spry removed Belinda from school, removing an important source of monitoring of Belinda's welfare. Mrs Spry had removed Anne from school just over a year earlier. Home education is quite legal and there is no right for local authority officers to require access to see the children.

4.6 Edward, the younger sibling of Carol and David, was privately fostered soon after he was born, and all three children then became subjected to successful applications for Residence Orders by Mrs Spry in June 1993. By this time Mrs Spry was caring for 5 children from the ages of a baby to 8 ½ years.

4.7 Social services did not object to earlier private fostering arrangements and did not make representations to the court in disagreement with the Residence Order applications. Information was provided to the court via reports from the Court Welfare Officer. Concerns were noted about potential long term care of the children by Mrs Spry, primarily because of her strong views and alternative approach to childcare. Balancing this, the Health Visitor submitted a report at this time that was positive about Mrs Spry's parenting abilities.

4.8 In summary therefore, Mrs Spry's application to be a foster parent, and then an adoptive parent, eventually went through without any strong challenges or dissention. Concerns were noted about Mrs Spry's abilities as a parent at the time, but, on balance, it was felt to be in the children's interests to remain with Mrs Spry and to have legal security of placement with her. The placements outwardly appeared to be satisfactorily meeting the children's needs. There is some suggestion that Mrs Spry's dominant personality was allowed to drive relationships with the statutory agencies.

Attitudes to child health, behaviour and developmental issues

5.1 At different times, Mrs Spry claimed that three of the children suffered with Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder and later that Carol suffered with Autistic Spectrum Disorder. She also claimed that Belinda was suffering from Asperger's Syndrome. To varying degrees the children received considerable specialist health interventions to address these problems. Health issues of this nature are not routinely shared with social services.

5.2 The review felt that the level of concern about behaviour disorders should have led to a review via a professionals' meeting to agree these children's treatment needs, the accuracy of any diagnosis, and the possible causes of the behavioural difficulties.

5.3 There was evidence of degrees of uncertainty in respect of the diagnoses of ADHD for all the children, and that Mrs Spry always spoke for the children, never let them be seen alone, and Ritalin was prescribed for excessive periods of time without the children being seen. Mrs Spry was insistent on the need for treatment and sought out private clinics, without agreement of the GP, to get a diagnosis to support the need for treatment. On one occasion the GP noted an

allegation (not known from whom) that Mrs Spry had been giving Belinda Valium, obtained from a neighbour.

5.4 This posed the question whether "Fabricated or Induced Illness" as a form of child abuse was perpetrated by Mrs Spry. It does not appear as though this was ever raised formally as a concern by any of the professionals involved with the children.

5.5 Following the car accident, it was noted by health professionals that in respect of the medical care given to Belinda, that even whilst in hospital, Mrs Spry "controlled the environment" and that Belinda continued to be a wheelchair user whilst in the care of Mrs Spry, despite there being no apparent physical reason for this. After leaving Mrs Spry's care, Belinda quickly regained her mobility.

5.6 Following the car accident in 2001 Belinda was considered for reconstructive surgery. Mrs Spry was not keen to pursue this and it is not apparent whether this surgery took place and the records do not detail the part of the body to which the surgery referred.

5.7 There was a difficulty for health professionals in conducting home visits, and doorstep visits were sometimes all that could be achieved. There was no effective coordination of the range of medical interventions and the number of failed appointments.

5.8 In summary, no opportunity was created to review all this information in the round and consider its significance in terms of the overall care of the children. The long period of time that these concerns continued, and the inevitable change of professionals during this time, meant that it was difficult to identify the necessary impetus for professionals to collectively review the interventions with the family. This meant that the work with these children was limited in its effect.

Family/Professional Relationships

6.1 Mrs Spry controlled the amount of contact that professionals could have with the five children. She removed all of the children from school to be educated at home, as permitted by law, which had the effect of preventing any day-to-day external view of their care.

6.2 Mrs Spry also either rejected or consistently changed planned appointments that were offered, making it difficult for all professionals coming into contact with the family to establish a clear view of the home circumstances and the care of the children.

6.3 Education services did nevertheless seek to maintain contact with the family on an annual basis, to monitor their education at home, and their education and situation appeared to be generally satisfactory. No child protection concerns were noted.

6.4 Mrs Spry was regularly described by the professionals who came into contact with her, as having "alternative views about life and parenting". She was also seen as being "powerful", "controlling" and generally difficult to work with. Nevertheless there were a number of occasions when professionals made very positive statements about her care of the children, for example that Mrs Spry was "very caring", a playschool leader described her as having "exceptional parenting skills" and a Police Officer said that he admired the way she cared for her children. There was a level of professional sympathy that developed for Mrs Spry as someone who was trying her best to care for five children, all of whom were seen as having some form of health or developmental problem.

6.5 Mrs Spry clearly had the ability to present an appearance to professionals of being a very able, concerned and caring parent, and to get them to take her side.

The Children's Health and Development

7.1 It appeared as though all of the children had poor or undeveloped social skills, and were generally seen as different or unusual, very much reflecting how Mrs Spry was also seen.

7.2 Issues of poor communication skills, either from poor physical speech, or simply from being uncommunicative, were a distinctive feature amongst the children. It is unfortunate some link was not made between the behavioural difficulties presented by the children were not linked to the environment that they were growing up in and the culture of care that they were receiving.

7.3 The younger two children were prescribed Ritalin for long periods of time and although its use should be reviewed every 6 months, this did not take place during the latter stages of the drug use.

The Professional Response to Referrals

8.1 The referrals made to Social Services during the 10 years between 1990 and 2000, included concerns about harsh treatment or excessive punishment of the children, but apart from the situation described in 4.3 above these referrals and the responses made to them did not result in continued social work involvement.

8.2 The responses to the referrals were, in themselves, appropriate and in keeping with practice and procedure at the time. However the referrals seem to have been seen in isolation, with no correlation of the referrals or identification of a concerning pattern of care which was emerging. Without this overview social services responded inconsistently and Mrs Spry's care of the children was not always appropriately challenged. Opportunities were therefore missed to fully assess the level of care of the children. However, it has to be acknowledged that these referrals spanned a long period of time, sometimes with significant gaps between them. Only on one occasion were the children individually spoken to about the concerns being presented at the time, although it was not clear if they were seen alone. On the occasion Mrs Spry was challenged by the social services in December 1991 the adoption took place in any case.

8.3 All of the children required some form of official sanction before they could reside within the family. Formal Reviews were held in respect of Anne and Belinda when they were in approved foster placements with Mrs Spry, and social workers were allocated to each child, a reasonable understanding of Mrs Spry's strengths and weaknesses as a parent was gained. Although childcare concerns were intermittently expressed, the positive attributes that were often also noted about Mrs Spry's care of the children seemed to outweigh these. However, there should have been greater scrutiny regarding the care that the children were receiving, particularly when concerns were expressed about their health and development, and the health interventions went uncoordinated. Greater opportunities should have been pursued to see the children on their own.

8.4 When, in December 2004 Belinda disclosed significant past abuse by Mrs Spry, there was a well-coordinated and appropriate response from the police and social services. The two remaining children were removed from her care. David disclosed serious abuse also as part of the initial investigation, and 6 months later made allegations of sexual abuse.

8.5 Within the Criminal Court Proceedings, evidence was presented in respect of dental treatment for Belinda, indicating that from 10 years old and on four occasions she was presented with broken or lost teeth. In evidence during the criminal proceedings the dentist stated that that he did not get the impression that they were non-accidental incidents and that he would have identified if they were unusual. Mrs Spry controlled when and where the children would be seen and they were invariably in her presence at such times and she also had the ability to present to professionals as an able concerned caring parent. Therefore it was not unusual for professionals to form a positive view of her care of the children and it is not apparent that the dentist challenged Mrs Spry in any way regarding Belinda's presentation with broken or lost teeth. Although the identification of child abuse within dentistry was not as well developed in the mid nineties as they are currently, there were obvious indicators of possible physical abuse that

as a minimum should have raised concerns for the dentist and led to a referral or consultation with another dentist or paediatrician.

8.6 No information has been presented about the number of optician's appointments for the children. It is not known if there were any child protection concerns relating to the need for opticians' appointments.

8.7 Children's dental and optician's appointments and attendances at the time, and currently, are only recorded internally and not on the wider Child Health system unless there has been a referral for specialist dental or eye treatment which is not the case here.

8.8 CAMHS were primarily involved with the two youngest male children (David and Edward) and then in respect of Belinda, although there was communication when the GP made referrals and when CAMHS wrote to the GP to pass on information following appointments. There was a level of uncertainty regarding the diagnoses being presented in respect of these children in terms of their behavioural problems and there was no corroborative evidence to support these diagnoses because they were educated at home. 'Shared Care Guidelines' produced by the Gloucestershire Health Community in 2004 state that a diagnoses of ADHD needs to be based upon a shared assessment between the parent and one other who knows the child (e.g. school). If a child is educated at home, s/he will be visited at home and observed in the home environment before a diagnosis is be made and treatment commenced.

8.9 In court Child C said that she had been hit by a bamboo cane and she had been seen by a paediatrician. It is now understood that Child C's visit to the paediatrician took place after the abuse was disclosed as part of the prosecution case. It was not something that was overlooked as part of any health interventions at the time.

8.10 The injuries to Belinda's skin in May 02 were considered to have been self inflicted but treated as a skin infection. Health information gained after the trial, reports that her face had large areas of abrasions but the dermatologist decided not to challenge Belinda or Mrs Spry about them. Mrs Spry was asked if she left Belinda on her own and the GP questioned her about the possibility of self-harm. Mrs Spry and Belinda denied this. At this time Mrs Spry was being overtly protective of Belinda and not allowing her to be seen on her own. There was no consideration regarding whether the facial injuries could have been inflicted as a form of abuse.

8.11 There were concerns about ear infections for Belinda at the time of her adoption medical and then in 1994 she received plastic surgery to correct a deformed ear that had been the subject of a GP referral a year earlier.

8.12 Belinda received medical attention from the GP between November 1996 and April 1997 because of bleeding from the ears and on the latter occasion Mrs Spry reported that Edward had kicked Belinda in the ear three months earlier but the incident was not recorded at the time. Mrs Spry told social workers that Belinda had been kicked in January 1998. If these reports relate to only one incident this is the second time that Edward has allegedly injured Belinda warranting medical attention on both occasions. In July 1997 a CAMHS report states that Belinda was deaf in her left ear due to an ear injury and two months later the ENT clinic reports that she has mild hearing loss. There is no definitive evidence to identify the exact nature of any hearing difficulty and how it was caused.

8.13 There is discrepant information in respect of the concerns that Carol run away from home. Additional information from the police after the trial has not clarified the matter. The discrepancies were not pursued at the time of the incidents and it is not apparent if social services or the police tried to understand if more than one incident had occurred. It is clear that Carol was too terrified of Mrs Spry to disclose any abuse. This clearly should have raised concerns for the police at the time.

8.14 Police Guidance published in 2005 regarding interviewing returned missing young people should now ensure that such matters would not be dealt with as lightly as occurred in this matter. The incidents of Carol running away were missed opportunities for more effective interventions.

Availability of Information to the Serious Case Review pre Mrs Spry's trial in Feb/March 2007.

9.1 The main health records would not include a record of dental appointments and only minimal reference was made to ophthalmic involvement, therefore there was no indication that health services needed to access these records to compile their IMRs.

9.2 Clearly it is important in respect of future Serious Case Reviews that when IMRs are requested all relevant files are secured. However this implies that it is known which files exist in respect of a child, when the experience of this case tells us that this is not always the case.

9.3 The additional information provided by the police does not significantly add to what was known by the Serious Case Review Sub Committee. What hampered the review was the minimal and somewhat sketchy record keeping by the police at the time and then trying to balance these with some apparent discrepancies from other sources.

Recommendations

1. When concerns arise about the care of children who are being educated at home, then a multi agency Professionals' Meeting should be called to consider the concerns and agree upon a response. Such meetings should be regularly held to monitor progress.

2. When children are the subjects of concerns, every effort should be made to see the children on their own as part of any Core Assessment. When parents or carers refuse to give their permission for this to happen it must be taken very seriously and the risk to the child must be assessed on this basis.

3. When children for whom there are concerns move across county borders, information sharing agreements must be established to ensure that all agencies working with the children are clear about their roles and responsibilities.

4. When there are identified multiple health needs for children, then a Health lead professional should be allocated to monitor, and if necessary coordinate medical interventions and if appropriate, establish clinical review meetings.

5. All records of Health, Education and Social Care professionals should contain a brief up-to-date chronology of significant events and interventions regarding families. This assists in giving professionals an overview of the situation with which they are dealing. This information should be included in any judgement about how to respond to any future concerns or referrals for a service to social care.

6. Management supervision for front line workers in all agencies working with children and young people, should address and help to identify effective "child in need" and "child protection" interventions with hard-to-reach and hostile families.

7. When child protection concerns arise in respect of children who have a legal status other than being the natural child of the carer, it is important for a Strategy Meeting/Discussion to establish the legal status of a child before deciding upon the appropriate response.

8. When child protection concerns are expressed unannounced home visits should be considered, to ensure that an effective response is made to meet the needs of the child's particular circumstances.

9. There is a need for formal links between School Nurses and the Educating Otherwise Service in order to maintain contact and provide a school nurse service with children being educated at home.

10. The GSCB should make appropriate representation to Government to highlight the concern that there is currently no legal process, which ensures that children, who are educated at home, are regularly seen, and their progress monitored, by Educating Otherwise professionals.

11. When a child is not attending school and there is a diagnosis of ADHD or other similar behavioural condition requiring medication, then there should be a source of secondary impartial information to verify that diagnosis.

12. All agencies should adopt one uniformed electronic template when producing chronologies for Individual Management Reviews.

13. In Court Hearings when significant changes to the care and circumstances of a child are being proposed, the children's views should consistently be sought and confirmed, and be available to the Court.

14. The impact on the lifestyle of children who are cared for by parents or carers, who display eccentric, unusual or rigid styles of parenting, should be thoroughly assessed. Child Protection training should emphasise that eccentric or unusual parenting must not be used as a reason to accept or excuse unacceptable levels of childcare.

15. The current Gloucestershire Police Missing Person Policy should emphasise that when the police locate a child/young person who has been missing, or has run away from home, they should: -

    - Seek to establish why that child/young person ran away.
    - Based on the reasons given by the child for running away and judgements by the officer involved, a child welfare concern should be logged and the Police Child Protection team informed.

16. All Gloucestershire General Dental Practitioners should be offered child protection training and child protection update training in line with that currently recommended by the General Dental Council and the GSCB Child Protection Training Programme. The experience of this Serious Case Review should be highlighted to identify the importance of such training.

17. All Dispensing and Ophthalmic Opticians in Gloucestershire should be offered child protection training in line with that recommended by their professional body and the GSCB Child Protection Training Programme. The experience of this Serious Case Review should be highlighted to identify the importance of such training.

18. The 'Shared Care Guidelines' produced by Gloucestershire Health Community (2004) in respect of management of ADHD and the prescription of relevant medication, must be promoted to and adhered to by all medical practitioners (GP's, Gloucestershire Hospital's Trust and Gloucestershire Partnership Trust).

19. When GPs refer children to medical specialists and after seeing the child, the specialist highlights potential safeguarding issues, then as a minimum the GP and/or the specialist, must consult with a Paediatrician/Designated Doctor, or make a referral to the Children and Young People's Directorate.

20. The manager, who is assigned to completing an Individual Management Review (IMR) in the support of a Serious Case Review, must enquire of, and seek access to, the records from the full range of service delivery functions that exist within the agency. This manager must confirm in the presentation of the IMR report, that a potential relevant sources of information have been

explored. Relevant enquiries of the family should be made regarding what services they have accessed, as part of the consultation with them regarding the review.

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