Gloucestershire
Safeguarding Children
Board

A SERIOUS CASE REVIEW

OVERVIEW REPORT

MEGAN

Chapter 1 – Overview Report

Executive Summary

1.0 Introduction

1.1 Gloucestershire Safeguarding Children Board (GSCB) commissioned a Serious Case Review (SCR), in October 2015 in respect of Megan a young girl who was placed with her Paternal Grand Mother (PGM) under a Special Guardianship Order (SGO) since 2012. She was found on presentation at a local hospital in June 2015 to be a victim of neglect and physical abuse, diagnosed by medical clinicians as non-accidental injuries (NAI).

1.2 Megan was six years old when she was taken to the hospital by her PGM and her partner and was described as "acutely unwell" with irritability, fluctuating consciousness level and hypothermic, with a high temperature; found to have low sodium levels, which required urgent treatment. It was noted she had extensive bruising to her body. Megan was assessed as very thin and small for her age and dehydrated. As the injuries were considered non-accidental, Megan was removed from the PGM's care whilst in hospital and placed into a foster care placement. At the time Megan was admitted to hospital she was receiving support from universal services only.

1.3 The Independent Chair (IC) of the GSCB, after additional information was received from Megan's school, agreed with the recommendation of the SCR Sub-Group that the criteria for commissioning a SCR was met in accordance with s5(2)(a) and (b) (i) LSCB Regulations 2006[1] and Working Together to Safeguard Children 2015[2]: -

- '*Abuse or neglect of a child or young person is known or suspected* and
- *the child or young person has died or been seriously harmed and there is cause for concern as to the way in which the Authority, their Board partners or other relevant persons have worked together to safeguard the child or young person*.'

1.4 The first SCR was completed using the SCIE methodology and approach in 2017 (the SCIE report). The SCIE report findings are subject to analysis and comment within this revised SCR Overview (OV) Report in Chapter 5.

1.5 The SCIE report did not cover the criminal investigation and outcome that ensued, due to a delay in the criminal investigation and criminal proceedings. This has now concluded and resulted in the arrest and subsequent conviction and custodial sentences imposed on her Paternal Grandmother (PGM), Megan's birth father C and the PGM's partner K for offences of Assault, ill-treatment, and neglect of a child or young person, and causing unnecessary suffering and injury. These charges were in respect of injuries sustained during the period when Megan resided in the PGM's home from January 2012 until June 2015. A fourth joint defendant, Megan's Paternal Aunt (PA), was found not guilty of all charges preferred against her. A possible allegation of Child Sexual Abuse (CSA) was not proceeded

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

with after consideration by the Crown Prosecution Service (CPS) after obtaining expert medical opinion.

1.6 Statutory Guidance

1.7 The DfE[3] provided statutory guidance and requirements on how to conduct a SCR which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led to individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data was collected and analysed; and
- Makes use of relevant research and case evidence to inform findings.

1.8 Purpose of the review

1.9 The purpose of this SCR is to: -

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

1.10 Periods of concern and key areas of consideration

1.11 There are five periods of concern identified in this SCR for consideration. These concerns are detailed within Chapter 3, Analysis of Key Events and Analysis of Professional Practice. This has determined the findings and recommendation identified for this review in Chapter 5. The key periods are: -

Period 1 - Background of Megan's case.
Period 2 - SGO Assessment of PGM.
Period 3 - Child Protection concerns and professional safeguarding practice.
Period 4 - Disclosure of Megan's physical abuse and neglect and police investigation.
Period 5 - Disclosure of Megan's abuse and neglect and subsequent criminal investigation.

1.12 Background

1.13 To ensure there was continued momentum of learning during the intervening period, the GSCB reflected on the findings from the initial SCR in 2017. They initiated Gloucestershire County Council's (GCC) authority and statutory role, to ensure the findings were shared throughout all the organisations working with children and young people (C&YP) within the County. The findings were adopted and implemented into all Single Agency and Inter-Agency

[3] Working Together to Safeguard Children 2015, Chapter 4 Guidance - HM Government March 2015.

Safeguarding training. This included Designated Safeguarding Lead (DSL) Forums for Education and Early Years settings and within GSCB (E) Annual Roadshows.

1.14 In September 2019, the GSCB Independent Chair (IC) made the decision to commission this SCR to reassess the 2017 SCIE SCR report, to consider the original findings and any legislative and guidance changes since the conclusion of the criminal proceedings. It has assessed and further analysed effective changes to professional practice in the interim period, as many individuals in the case no longer work for Gloucestershire organisations and some of the evidence is now 9 years old. The SCIE report does not contain any comments from family members and consideration of their participation and engagement will subsequently be made by the GSCE.

1.15 This new SCR OV report complies with the National Panel's guidance set out in the Child Safeguarding Practice Review Panel: Practical Guidance (April 2019). It has considered the findings of the first SCR and has updated them in light of events since June 2015 and addresses the questions (See Chapter 2 terms of reference) set out in the specification for the first report. The review seeks to identify any learning which remains relevant for improving professional practice. (See Chapter 5).

Chapter 2 – Initiation of the Serious Case Review

2.0 Terms of Reference (summarised).

2.1 The full version of the TOR is available from the GSCE. The focus of this current SCR is to take an overview of the 2017 SCIE SCR and to analysis implementations and changes to effect professional practice in the intervening period taking into account the outcome of the recently concluded criminal proceedings.

2.2 Scoping period

2.3 The timeframe for the Review is between **July 2011** and **June 2015**.

2.4 General Terms of Reference for Review

2.5 The SCIE utilised a Review Team process and gave consideration to the following research questions which this review has also considered: -

- How do professionals in Gloucestershire understand their safeguarding responsibilities during the SGO process, from assessment onwards?
- How robust and effective is the response to children's low school attendance regardless of whether they reside with their parents?
- How well do we share information and understand risk within the extended family (wider relationships)?
- How confident are professionals in Gloucestershire in recognising and understanding all types of abuse?

2.6 Family Composition and Children subject to the review

Subjects of the SCR	**Pseudonym if used**
Subject	Megan - aged 5 year in June 2015
Paternal Grandmother (PGM)	Convicted of Megan's cruelty and abuse
Birth Father (BF)	C - Convicted of Megan's cruelty and abuse
PGM partner K	K - Convicted of Megan's cruelty and abuse
Paternal Aunt, PGM elder daughter and half-sibling to Megan	PA - Found not guilty of Megan's cruelty and abuse.
Paternal Uncle	Paul - Younger child of PGM, aged 9 years in June 2015

Birth Mother (BM)	Amanda- was not subject to the SCIE or this SCR review.
Sister – half sibling	Charlotte – aged 7 years in June 2015

2.7 Methodology

2.8 The Independent Author of this review reviewed all SCIE SCR 2017 documentation and met with two key professionals, the Head of Service Permanence and a GCC Legal Service lawyer for the purposes of understanding the SGO practice and assessments in 2011 and processes currently now in place within the County. This review has also assessed and captured subsequent changes to the recent SGO Guidance (January 2017), and reviewed a recent case stated in the Court of Appeal in 2018 regarding SGOs, in order to understand available guidance for professional practice. (See Findings and GSCB Overview Report Recommendations in Chapter 4).

2.9 Independent Overview Author

2.10 The Independent SCR Author (IA), David Byford, was appointed to carry out the SCR in September 2019 and has met all deadlines set by GSCB.

2.11 Family Involvement

2.12 The family did not participate in the SCIE review due to the criminal investigation that was ongoing at the time. A decision regarding participation in this updated review will be made by the GSCE as alluded to in Chapter 1 at a later stage.

2.13 Publication

2.14 This report is published in accordance with the Working Together (2015) and Working Together (2018).

Chapter 3 - Analysis of Key Events

3.1 The key events together with the input from the agencies and practitioners participating in this review. They have been anonymised and summarised to show how the concerns developed over the five time periods, together with the professional action taken.

3.2 Period 1 - Background of Megan's case

3.3 Megan's life story and family background

3.4 In 2009 Megan was born almost eight weeks premature. At the time of Megan's birth (exact date redacted) there were professional concerns about her birth mother, Amanda's capacity to care for her. As a result, Megan was made subject of a Child Protection Plan (CPP) under the category of neglect, along with her half-sibling, Charlotte.

3.5 In February 2010 the concerns remained, and the Local Authority initiated care proceedings and Megan became a Looked after Child (LAC) now also referred to as a Child in Care (CIC). Interim Care Orders (ICO) were granted for both Megan and Charlotte with a direction that assessment work would be undertaken in a residential setting. Following an intense assessment, Amanda was deemed unable to care for either for Megan or Charlotte.

3.6 Charlotte was placed on an SGO with her PGM. A Social Worker (SW) explored whether Charlotte's PGM could also take Megan, but this was not possible. Megan remained in foster care whilst a number of viability assessments were completed by a SW with family members, in the search for a suitable permanent carer for her and to conduct DNA testing to establish who her father was. The long-term plan for Megan at the time was adoption or placement with family members.

Analysis of period 1

It is clear child protection processes were efficient and appropriate to protect both Megan and her sibling at the time. There was forward thinking to obtain a long-term solution for Megan being carefully considered. Professional practice at this point was effective and proportionate with the 'best interests' of both Megan and Charlotte being taken into consideration.

3.7 Period 2 - SGO Assessment of PGM (July 2011 until January 2012)

3.8 DNA testing established C was her biological father. Gloucester Children Social Care (GCSC) having conducted a parenting assessment, decided Megan would not be placed with C as a viability assessment deemed him unsuitable to care for Megan, but she should be placed with his mother, the PGM.

3.9 Care proceedings for Megan were already underway when her father was identified. It is reported the SW felt under immense pressure from the court timescales and line management to identify another family member. Court proceedings for both Megan and Charlotte had been ongoing for 50-weeks and was over the agreed 26-week time limit set. The SW was mindful of the Family Justice Review (2009) which had highlighted care proceedings drift and delay for children. The SW felt C's mother, the PGM, was a likely applicant for an SGO and a better option for Megan because it would ensure she kept contact with her mother Amanda and her half-sibling Charlotte which an adoption order would potentially sever.

3.10 During this period, safeguarding practice ensured Megan's foster placement was subject to regular LAC reviews chaired by the Independent Reviewing Officer (IRO) who was aware the care proceedings were going ahead.

3.11 Concerns raised by professionals and the PGM regarding the SGO process

3.12 Significantly in December 2011, Megan's foster carer provided, through the LAC Review process, written concerns regarding the sporadic contact between Megan and her PGM who was being assessed for an SGO. She was of the opinion as Megan did not have a pre-existing relationship with her PGM, she was showing separation anxiety. Given this concern to find a relative at such a late stage, the SCIE review reports the IRO felt the courts would make a decision on the SGO and would be in favour of it. The IRO was clear he had a responsibility to ensure other permanency plans were considered but the court process dictated timescales and he thought his reviews were therefore not so influential. He also felt it was not unusual for a child who was moving out of a placement to show separation anxiety or for a foster carer to express concerns, especially if the carer was also hoping the child could stay with them for longer.

3.13 Megan's paternity was discovered very late during the proceedings. The PGM was 37 years old at the time and had not had time to assimilate being a grandparent having a primary school aged child herself. It is evident the SW did not request extra time from the court to enable PGM to consider the implications of taking on another child under an SGO. The court appointed Guardian advised accordingly that the PGM herself was worried about the speed of the assessment and the SGO.

3.14 As GCSC were not requesting additional time from the court, the appointed Guardian wrote to the solicitor to ask the court for a delay because the PGM was concerned about bonding with Megan. The SW advised he was holding a very high case load and was also mentoring newly qualified SWs. The SCIE report highlights senior line management was adamant court deadlines were met as the Local Authority had been deemed inadequate for safeguarding by Ofsted. Apparently, this was added pressure and an apparent morale issue amongst SWs within a culture that allowed managers to sign off reports for SGO cases from SWs they trusted without seeing them, in order to save time.

3.15 The PGM during the processes of assessment was noted to be 'emotionally flat' at times by the SW and also by a health visitor (HV) engaged with Megan's case. Visits to the home were not comprehensive in their observation of the layout of PGM's home. Introductory sessions between PGM and Megan were held in an unsuitable room for play, taken up almost entirely with a table. There was no challenge to meet elsewhere as the full extent of the house was unknown by most professionals although it was tidy and sparse there was little evidence of PGM's own child, Paul, being there. Paul was not seen by practitioners or assessed as to the likely impact on him having Megan permanently living with him and his mother and should have been part of the overall assessment.

3.16 Reading documentation, it is also reported PGM had financial difficulties which would have been significant considering the additional expenditure of having Megan reside with her. She declared herself bankrupt in 2010. Consideration of the additional pressures of a child with additional needs and possible financial motives for taking on an SGO were not considered as part of the assessment. Regulation 12 of the Special Guardianship Regulations 2005 (relevant and in place) shows the overall assessment for PGM's assessment , for Megan's

SGO, was not thorough. GCC are now addressing issues regarding applications for financial support for SGOs.

3.17 In January 2012, Gloucestershire Family Court Proceedings directed that Megan be placed with the PGM on an Interim Care Order (ICO) with a view to an SGO to be made at a later court hearing. Megan (who was two years old), moved into PGM's three-story property in February 2012. During the following period Megan's birth father C also came to live in the home as he had split up from a previous partner (not Megan's birth mother Amanda). PGM's partner K moved in whilst Megan lived there. The PGM's older daughter, Megan's Paternal Aunt (PA), was also a regular visitor to the home. She was to become the fourth defendant in a criminal trial but was the only defendant who was subsequently found not guilty of any offences against Megan.

3.18 In April 2012 the Court granted the SGO to PGM with a Contact Order attached (The Adoption and Children Act 2002 allows SGOs to be granted with Contact Orders attached). This was to ensure Megan saw her sibling Charlotte on a regular basis. There had previously been some concern surrounding Megan not being taken for contact with Charlotte by PGM (possible lack of engagement issues and not considering Megan). PGM did not like these meetings and felt she was being looked down upon by Charlotte's PGM. A decision to grant the SGO without any professional challenge was made. PGM felt she was 'doing this for her son.' The fact she was a new grandmother, with no previous relationship with Megan was not explored.

Analysis of period 2

The viability assessment of the PGM for the SGO was completed too swiftly (only nine weeks after PGM was identified as a relative) due to court timescales and pressure on the SW, her team and the IRO LAC process. There was no attempt to request the court to extend the time considering the late identification of a family member to be considered for the SGO. There appears a lack of support being provided to the PGM following the SGO.

It is not clear if the PGM fully understood the enormity and permanence of what the SGO involved? Professional practice and the actual assessment process was therefore below the standard expected. Practitioners were of the apparent predisposition of keeping a child with the family wherever possible, and believed the SGO would inevitably be agreed by the Court, a preconceived practitioners' assumption, in any case.

Initial Family and Friends Care Assessments: a good practice guide (2017)
Staying Put: good practice guidance

The guidance states, *"In assessing the suitability of a child living with a relative or friend or other person connected with the child as an alternative to care proceedings, local authorities will need to consider what support might be required to enable the arrangement to be successful, whether informal or by way of special guardianship or a residence order. Whether family members and friends are caring for a child or young person who would otherwise be looked after, who is already looked after, or is returning from a care placement, it is essential that proper recognition and effective support are given to ensure that the carers are able to safeguard the child and promote his or her welfare, and so achieve their full potential."*

Considering the concerns from the Foster Carer (FC), HV and the appointed Guardian as well as the concerns of the PGM; her reported 'flatness'; who felt the whole process was being rushed,

together with her financial difficulties, the outcome of PGM's assessment was seriously flawed. The whole process notwithstanding was over the normal prescribed time limit set, including the LAC review opinion, it is suggested the assessment was not completed to a professional standard of practice, failing to consider all the concerns and issues in the 'best interest' of Megan. The SW and professionals were over optimistic about PGM's capacity to parent another child and care for Megan and that PGM wanted Megan to know her natural mother. The SW believed the PGM had some empathy for Megan retaining a relationship with Amanda and Charlotte, with contacts arranged between PGMs, even though Megan's PGM did not like the meetings.

The SCIE reports "There was a very strong and shared professional perception, based on experience, that an SGO would always be granted because they were the preferred option of the court and therefore quick and less robust assessments and reviews were all that was required." This review agrees with this finding. The SGO application report provided by the SW for the court was also reviewed. It was too optimistic of PGM and did not fully outline the underlying concerns and comments from professionals and PGM herself which should have been identified within GCSC supervision and discussed with the SW prior to completion.

Despite the lack of a pre-existing relationship (SGO 2005 Regulations) with Megan, it is possible that the minimum of assessment was carried out to satisfy the court. Given no request for extension was made we do not know, due to the circumstances of identifying PGM late in the care proceedings, whether a Judge may have, in the best interest of Megan, allowed an extension? No attempt was made to request an extension despite the fact that there would have been a strong argument for such an extension given the issues identified by this and the SCIE report.

The findings from this review and the recommendations made in Chapter 5 propose that the assessment of SGO applicants should include an extra level of safeguarding to take away the presumptions, optimism, and worry of professionals meeting timescales in order that a thorough assessment is conducted. Assessments need not only to consider the short and medium term, but the long-term period of caring for Megan and other children and young people for the future.

3.19 Period 3 - Child Protection concerns and professional safeguarding practice

3.20 Megan, having moved in with her PGM in April 2012, continued to be seen at the home by professionals. Her case was later closed to GCSC. In March 2013 Megan started at nursery school and had contact with and was seen by the Health Visiting Service (HVS) and with a local Children's Centre for contact.

3.21 **Additional support.** There was no additional support for children placed on SGOs at the time contrary to when a child is placed for adoption or fostering where there is regular contact and support provided. Once an SGO has been applied, there is no statutory duty for the special guardian to accept or comply with training or to accept support as they have parental responsibility, and not the Local Authority. Each child on an SGO will have an SGO Support Plan but this is not shared with statutory agencies and these issues were explored and addressed by the SCIE SCR discussed within Chapter 5.

3.22 It is evident to this review, and from the SCIE findings, that there was a distinct lack of awareness and understanding of the different types of care orders known to some professionals particularly in the educational setting. SWs in contrast are aware of the separate care plans and their function, and learning has since been implemented to ensure knowledge of various care plans is known more widely.

3.23 Recognising signs and symptoms of neglect and abuse

3.24 Neglect issues at the nursery from March 2013. Megan attended her nursery sporadically and missed sessions which staff understood to be for 'family reasons.' She attended only three out of a possible ten sessions in March 2013. Staff were not alert to any issues regarding Megan's previous vulnerability because they had not received any contact from other professionals. Staff were clear in their minds and reported during conversations they thought PGM was Megan's maternal grandmother (MGM) which was not correct. Staff had no understanding of an SGO and did not show professional curiosity about the family dynamics or made cursory checks. With the exception of social care, all other agencies involved with Megan and her family were unclear about what an SGO meant and who would be involved in it.

3.25 On one occasion, Megan attended the nursery when she was very cold, and her lips had turned blue. This was reported to the manager by nursery staff and discussed with the PGM who responded to say Megan 'is very small and feels the cold' which this review believes was dismissive and should have been challenged with the PGM further. There was no consideration to explore this incident further.

3.26 Staff were also aware Megan walked to nursery with the PGM and also went with her to collect Paul from school which was a further five minutes away. Megan on occasions was seen to attend the nursery without a jumper and wearing clothes that were too big for her which, nursery staff believed were 'hand me downs' from a sibling and was not followed up.

3.27 Family and Friends and Children Centre - May to November 2013. In May 2013, a Fostering Support Officer (FSO) from the newly formed Friends and Families Team contacted PGM by phone because of concerns about her attitude towards Megan which were noted during contact with her sibling Charlotte. PGM, who had been a Special Guardian for 15 months to Megan, ***'expressed a feeling that she had made a mistake in agreeing to the SGO. She stated that she had not bonded with Megan and found it hard to like her'.*** She said she had only taken on the SGO to help out her son. In response, the FSO conducted a home visit on 16th May 2013 and suggested a parenting course for the PGM to attend but she refused. The course was not mandatory and the focus of work between PGM and the Children's Centre appeared to discuss PGM's concerns about her housing and neighbours without really addressing any parenting needs, so was a missed opportunity. There should have been communication with GCSC regarding what the PGM was saying and for the consideration of a professionals meeting or strategy discussion to fully understand Megan's health and wellbeing more widely.

3.28 A Community Nursery Nurse from the health service did a joint visit with PGM and Megan and did not feel there were any concerns. The practitioner also rang Megan's nursery and asked if they had any concern about learning and development, but they had none.

3.29 Admission to school September 2014 to February 2015 and PGM's lack of engagement. Megan started school in September 2014, and there was a lack of information sharing as both the nursery and school accepted the GP details were not included on the admission forms and did not follow up and make enquiries. The Nursery had not received, nor sought any information regarding Megan's previous vulnerabilities and nothing was passed to the school.

3.30 The school only had brief information from a form PGM completed which stated Megan lived with her and was allowed to see her mother once a month. PGM's application for a school place for Megan stated Paul was her older sibling when he is in fact her PU. Gloucestershire County Council Admissions were concerned this was an attempt to get Megan into the school under 'sibling rules' and identified Megan and Paul were not siblings. The lack of a central process at this time to assist children on SGOs to attend the most convenient school also meant that the school were not alerted to the SGO and previous vulnerabilities.

3.31 The school checked whether Megan was a LAC with the Virtual School (for children in care) who confirmed she was not, and now lived with her PGM. This reassured the school they did not have to make special arrangements or seek external support for Megan. The SCIE report in conversation with practitioners confirms the PGM had already started to disengage and the school found her very difficult to become involved in Megan's school life. She was not available for the school to visit at home prior to Megan starting at the school and had not brought Megan to any pre-enrolment fun days.

3.32 By January 2014 Megan's attendance at school had dropped to 87% (Local Authority trigger point for intervention is 85%). The reason for this was cited as head lice, despite this was not a justifiable reason to keep a child off school. Due to her poor attendance in January 2015, the school asked their Education Welfare Officer (EWO) to speak to PGM regarding attendance but she failed to engage.

3.33 Lack of food. Later in the month Megan said she was hungry in school. The lunchtime staff spoke to her class teacher about this and Megan was offered additional bread and salad. Megan told her teacher she had only had toast for tea the night before and the same for breakfast that morning. The next day, Megan was tearful and hungry and said she had only had toast again. The class teacher referred to the Designated Safeguarding Lead (DSL) for the school but was asked to address the concerns directly with PGM.
Comment: ***This was an opportunity to raise the issue with other professionals, as concerns were evident. There was a need to consider sharing the information (meeting or strategy discussion) as before with GCSC and to capture the wider dimensions of Megan's life with PGM. This was a sign of neglect not acted upon.***

3.34 One month later, Megan, along with some others, helped herself to a second piece of fruit in the classroom, something that had previously been discussed as not acceptable with the children in class. Megan was awarded a sanction along with the others as a consolidated approach. However, the fact Megan had previously been hungry in school was not seen as a potential concern. There was no robust understanding of neglect by staff and the DSL. Megan was tearful and hungry and PGM's reported response was to grab Megan's wrist and say that she was lying. This was again a failure and a missed opportunity on the school's part to recognise the signs of neglect and inappropriate chastisement, to share the information with GCSC. Throughout the period there were numerous concerns raised by professionals regarding PGM and her behaviour towards Megan by the school.

3.35 GP issues. NHS England does not require a GP practice to make local enquiries or check with other agencies on the whereabouts of a Looked After Child during this period, however, some GP practices do show good practice and make such enquiries regardless. This did not occur in Megan's case who had missed two immunisation appointments, a potential sign of parental non-compliance which did not trigger a response considering she was a previous LAC (although unknown by some professionals)

Analysis of period 3

What is worrying in this case is the noticeable absence of hearing the voice of Megan and when she did raised concerns it was not fully explored or acted upon sufficiently. PGM's attitude and the behaviour she displayed when spoken to about Megan being hungry and her presentation at school showed she was unengaging, unsympathetic and lacking in care, grabbing at Megan and calling her a liar, after disclosing she was hungry to staff.

Furthermore, it is now known the serious cruelty, neglect, physical and possible child sexual abuse Megan sustained, was occurring during this period with practitioners not recognising any signs and symptoms. There was also no evidence to suggest they were even considering the prospect. She was under weight and having expressed she was hungry to school staff. The staff, other than speaking to the PGM, did not challenge her further, accepting her dismissive comment that Megan was small. Staff showed insufficient professional curiosity.

There were missed opportunities and a failure to share potential safeguarding concerns with other professionals, notably GCSC who were fully aware of Megan's vulnerabilities, her background and family dynamics but it is noted there was also no communication between GCSC in return to share information that Megan was a previous LAC and had been a subject of a CPP for likely neglect by her mother, Amanda. Concerns permeated from the Nursery, FSO, Children Centre, HV, and her school and DSL but there was no joined up working or exploration of Megan's lifestyle with PGM or the fact PGM did not bother registering Megan with any GP Practice.

The Children's Centre did contact the nursery, but they had no notable information. PGM refused a parenting course for her reported poor attachment with Megan and a recommended visit by the Community Nursery Nurse (CNN) for a follow up assessment did not take place and was never challenged. The school also did not identify a pattern of Megan's absence which also occurred at her previous nursery. No practitioners effectively obtained Megan's family history and there was a distinct lack of supervision oversight which is a finding in previous Local and National SCR recommendations.

Gloucestershire Neglect Tool 2018.

Previous SCRs have made recommendations for the Gloucestershire Neglect Toolkit 2018 to be fully promulgated throughout the County. This is necessary guidance to assist practitioners to recognise the signs and symptoms of neglect and abuse and is being rolled out as a result of the initial SCIE report findings and other Local and National SCRs recommending the urgent implementation of neglect tools to inform professional practice.

3.36 Period 4 - Disclosure of Megan's abuse and neglect and subsequent criminal investigation

3.37 Megan was admitted to (Hospital 1) on Sunday 14 June 2015 at 8am due to a potential sickness bug. She was taken there by her PGM and her partner. Megan was described by clinicians as "acutely unwell" with irritability, fluctuating consciousness level, hypothermic with temperatures of 34.1 (within a normal range 36.1-37.2) she was found to have a low sodium level, which required urgent treatment. Investigations to detect infection were normal as were the CT brain scan and a chest x-ray.

3.38 On admission, medical staff also noticed Megan had significant bruising to her body. There were inconsistent explanations for these injuries given at the time by her PGM. Due to the medical concerns, Megan was appropriately admitted to the High Dependency Unit (HDU)

with dehydration and suffering from convulsions. She was noticeably thin and small for her age. Body mapping was carried out and showed extensive bruising all over her body. (Police subsequently took over 90 photographs of her injuries).

3.39 After the concerns were disclosed a strategy meeting (SM) was held where medical professionals confirmed Megan's injuries were NAI in nature. Megan was immediately removed from the PGM's care and placed with foster carers under a S20 agreement and Care Proceedings instituted.

3.40 The SM heard neighbours in the area had reported Megan was being shouted at and was often in her room. Furthermore, the concerns raised in the analysis in Period 3 above were discussed which would have been better served by an earlier professional's meeting or Strategy Discussion (SD) when concerns were first noticed.

3.41 Initial attempts by Police and SWs to speak with Megan were unsuccessful as she was falling in and out of sleep. PGM was spoken to regarding information about unidentified boys being responsible for Megan's bruising. It was suggested Megan had been sick all week, but on the Saturday night she was feeling better, so she allowed her to go outside the front of the house to play on her scooter. At about 8pm to 9pm, Megan came in crying and stated boys had tried to take her scooter and kicked her in the legs.

3.42 In the early hours PGM said Megan was being sick in the downstairs bathroom; PGM apparently assisted but left her in the bathroom. She then heard a thud in the bathroom and went in and Megan was on the floor and appeared to be having a seizure. She appeared slightly blue as if she was choking but then appeared ok. In the morning she decided to take Megan to hospital because of the seizure. When asked about the bruising on Megan's arms she stated Megan caused this by being clumsy hitting her arm on the Wendy house in her bedroom. In relation to a bruise on her head, she believed Megan did this when she fell in the bathroom.

3.43 On Monday 15 June 2015, a SW and Police Officer spoke with Megan. She stated all the bruises were down to one boy who had dark hair that he tried to take the scooter off her when she was out the front and when she would not let go, he kicked her 5 times and her granny (PGM) came out and told the boy off. The leg bruises, arm bruises, head bruises were all put down to the boy kicking and punching her. It was noted however there were inconsistencies about PGM's account and not speaking or ever seeing the boys in question. The following day PGM was arrested on suspicion of child cruelty and Actual Bodily Harm (ABH).

3.44 Police officers conduct a Section 18 search of the home address even though PGM told officers no one else was at the address, C was found to be there. He said he had not seen any bruising, suggesting as his mother had said that Megan was quite clumsy always falling over; she bruised herself on a doll's house and 3 or 4 days previously was seen slipping down the stairs, but had no injury. He had been staying at PGM's address since the Friday or Saturday. He was not sure if Paul was at home although he apparently was looking after him on the Sunday when Megan was taken to hospital in the morning.

3.45 Megan for her own safety was placed into a foster placement. She had no clothes to come home in from hospital, with clothing provided by another parent visiting their own sick child. On 5 August 2015 a statement was taken from PGM's partner K, who was initially treated as a witness due to Megan's staged disclosures over time to police. Throughout Megan's time

with her FC up until September 2016 she made disclosures of physical, emotional and sexual abuse about what had happened at home in the care of PGM, C (her birth father), PGM's partner K and her PA.

Megan's Story

3.46 **First police interview with Megan disclosing the cruel lifestyle she had to endure**

3.47 On 22 September 2015 Megan conducted her first ABE interview with police. She disclosed 'Granny did not look after her properly; she smacked her bottom, back, tummy and made her feel sad and did not know why her granny smacked her.' She also disclosed 'Daddy smacks her and hits her with a wet tea towel and his hands.' This occurred in her bedroom whilst she was in her pyjamas and happened every day. She would feel sad and cry. Granny would say "shut up".

3.48 Megan would eat alone downstairs, after tea she would have to go upstairs and hold a heavy Lego box above her head. When she was in bed PGM would not allow her door to be left open making her feel sad and frightened. She stated Paul and her PA were not kind to her and no one loved her, no one put her to bed, she had to dress and look after herself.

3.49 Megan confirmed two boys had took her scooter and one of them kicked her and also disclosed PGM's partner K would hit her with a towel whilst she faced away, granny would make her stand and not face her and tell her to stop crying. She did not get cuddles from PGM or her father as 'they did not like her," She was not allowed to watch TV, not allowed in the living room and would get a smack if she went into the room. She felt sick because her legs were sore when the boys kicked her.

3.50 **Further arrests**

3.51 On 30 September 2015, the PA, C and PGM's partner K were all arrested on suspicion of child neglect and cruelty on Megan.

3.52 **Second Megan ABE interview with further disclosures of cruelty and abuse**

3.53 In January 2016 Megan completed a further ABE interview where she disclosed K hung her on a door and when she fell off, with PGM present, they put her back up and this made her feel sad. Both PGM and K made her eat "dog poo and threatened to chop her fingers off". She then talked about C putting her in a suitcase and threatening to push it down the stairs. When she was in the suitcase it was K who closed it over her. The mental stress Megan was going through was immense she even disclosed PGM wanted to drown her in the bath.

3.54 **Megan's further disclosures given to her foster carer of cruelty and possible child sexual abuse**

3.55 After these concerning interviews with police, Megan made more disclosures in her foster placement and further offences came to light. An ABE interview was conducted with her in August 2016.

3.56 She further disclosed 'Granny and K touched her (private parts) and bottom. Both of them did it when she was on the floor outside her bedroom, she did not have clothes on. She states her PA, Daddy and Paul were in the house when it happened however, they did not

see it. Megan said she cried when they touched her private parts. She said when PGM and K touched her, she had blood in her underwear.

3.57 A 'green face' would come into her bedroom in the night; she would hide under the covers as she thought it was going to eat her. It would bang and she was sure it was not a dream and believes it was her PA who painted her face to scare her.

3.58 The bedroom door would be locked, and she knew this as she shouted for help and it was locked by K. She made reference to being hit with a blue flannel and her bottom. She said when she is in the bath, she had to hold her hands above her head and PGM would then touch her bottom. She told her to stop and this is why she had to hold her hands up out the way. She mentioned to the foster carer that K had his tongue out 'like Mr Potato Head' when he was rubbing her, indicating between her legs.

3.59 **Professional opinion, further assessment of Megan**

3.60 Additional professional opinion to support Megan's disclosures was sought. In February 2017 Megan completed a safeguarding Paediatric Assessment by a Community Paediatrician. There were no evident signs Megan had been sexually abused but this could not exclude the possibility that abuse had occurred.

3.61 A registered Dental Surgeon identified bruising to Megan's upper outer left thigh which stated it could be a possible bite mark as defined by the British Association for Forensic Odontology.

3.62 In March 2017, a fingerprint officer commented on the orientation of Megan's left palm on the door in relation to her disclosure of being hung from doors. It provided a picture to illustrate the position and orientation of where Megan's palm was on the door.

3.63 In May 2017, contact was made with the National Crime Agency (NCA) to assist with an independent consultant Paediatrician expert to give advice on Megan's case, with a result received in August 2017. In conclusion the expert recorded there is clear evidence of neglect of Megan's nutritional, emotional and developmental needs with failure to adequately protect and ensure access to healthcare. In the expert's opinion Megan had been subjected to longstanding severe neglect and emotional abuse, significant physical abuse and sexual abuse.

3.64 Witnesses statements were obtained from practitioners, Megan's half sibling Charlotte's PGM and neighbours, two of which described concern and rough handling of Megan and described Paul as being spiteful towards Megan when seen together. One neighbour provided a statement and said she has seen the PGM grab Megan's hands and then smacked Megan's own hands into her face. She described the PGM as being really spiteful. She also witnessed the PGM and Megan in the back garden where the PGM was feeding Megan and the dog off of the same spoon. (Why these events were not reported to police is unknown).

3.65 During the criminal investigation, all four defendants made no admissions to the allegations made, when subsequently interviewed by police. All four suspects were eventually charged on the directions of the CPS.

Analysis of period 4

Megan's voice has to be heard, as outlined above. Her home life in the PGM's home can only be described as a Dickensian lifestyle that should not and will not be accepted in society today. Her story is a lesson as to what can happen when processes are not completed and followed to an acceptable professional standard.

The police investigation was subject to delay. When it was eventually concluded, it was a thorough and effective investigation and received a subsequent positive outcome in court against cruel and abusive individuals. Police were sympathetic with Megan, capturing her story of the horrendous living conditions and environment she had to contend with at such a young age.

Police themselves considered the case was unreasonably delayed and an example of drift which was an issue within the Chid Protection team at that time. It must be noted however, additional expert opinion was needed to be obtained in order to proceed with the investigation. There were two main reasons for this particular delay: -

a) A lack of urgency in progressing the investigation. There seemed to be a view as Megan was safeguarded, there was no urgency to progress the case, and a lack of supervision and direction is noted.
b) Following the completion of the physical assault allegations, Megan made allegations of sexual assault. These were then investigated and reviewed by the CPS which caused further delay to the investigation and a charging decision. It was decided there was insufficient evidence to progress this aspect of the case.

In March 2017 a senior police officer was brought into the department to change culture and improve investigations. Before this, the quality of investigations had been assessed as poor by the HMIC during their Child Protection inspection of Gloucester Police in early 2017. As a result of the action taken, improvements to the culture and investigations were made and during the 2018/2019 PEEL inspection published in 2019, Gloucester Police were graded as good with positive comments for vulnerability.

3.66 Period 5 - Outcome for Megan and of the Criminal Proceedings

3.67 **Megan -** The outcome after child protection action taken to protect Megan in June 2015 was extremely positive. Megan is currently in a long-term foster placement (since September 2016) in a different area and is thriving. She is at an expected level at school and partakes in activities outside of her school environment.

3.68 **Court Proceedings outcome -** In 2019 the criminal court proceedings concluded after the CPS made the decision to charge PGM, her partner K and Megan's birth father C and the PA with the following offences against Megan: –

3.69 **Charge 1** - Assault, ill-treat, neglect, abandon, a child or young person, to cause unnecessary suffering or injury (**for period 21/01/2012 - 14/06/2015**).
Charge 2 - Assault, ill-treat, neglect, abandon, a child or young person, to cause unnecessary suffering or injury, (**for period 24/01/2012 - 14/06/2015**).
Charge 3 - Assault, ill-treat, neglect, abandon, a child or young person, to cause unnecessary suffering or injury, (**24/01/2012**).

3.70 PGM was found guilty of all three charges and received a substantial custodial sentence of 7 years. PGM's partner K and Megan's birth father C were charged with Charges 1 and 2 and were found guilty and received custodial sentences of 2 years and 3 years 6 months respectively. The PA was found not guilty of all the offences charged during the course of the trial. Megan's subsequent disclosure of CSA was considered but was not proceeded with. Expert opinion states *'although there was no physical evidence it does not say it did not happen.'*

Chapter 4 – Analysis of Professional Practice from 2011 to 2019 and the way forward

4.0 The Independent Author met with the Head of Service (Permanence) and a Lawyer from Legal Services to establish what were the contributing factors at the time of the original review; changes and implementations that have since been made to improve practice since 2017 and the way forward as follows: -

4.1 Contributing SGO factors in Megan case

- SGO assessments were completed by the children's team who were allocated to the child.
- SGO carers had no relationship with the SGO team who were going to support her longer term.
- The family came forward late in the proceedings and the relationship with Megan was not established.
- SGO Support plans were not quality assured by the team responsible for supporting SGOs.
- PGM had not previously engaged in contact with other children and did not engage in support or with professionals.
- There was no SGO training for SGO carers who were going to be caring for traumatised vulnerable children.
- There was a lack of knowledge available about SGOs (including Health and Education) and what it means for carers legally and in relation to future support and help available and what support and oversight is required.
- There was no testing of the arrangement.

4.2 Changes made since 2017: -

- SGO carers received training delivered by an experienced SGO carer.
- Information leaflets and packs are available for potential carers before and during the assessment process are made available.
- Assessments are completed by social workers who are experienced in kinship care and are aware of the support likely to be required in the short/medium and longer term based on their experience of supporting carers.
- The assessments and support are held in a specialist team who manage all friends and family arrangements and support.
- All SGO arrangements have 4 visits per year following the granting of the order. This is not statutory, but the majority are complying.
- Monthly support groups for SGO carers facilitated by a family support worker from the specialist kinship team are held.
- There is an annual SGO get together 'picnic in the park.'
- An SGO newsletter is sent to all SGO carers who can also access fostering carers training.
- Consultations with a social worker and child psychotherapist is available to the SGO to help them care for and understand the needs of the children in their care.
- GCC fund pre-school and nursery for children in SGO arrangements ensuring they have a range of professionals involved in their care and allowing the carer to work and or 'recharge their batteries' with a variety of initiatives such as holiday activities, an annual review of the support (postal) of SGO arrangements, SWs attend TAC meetings where required and support the carers and work in collaboration with the

children's teams on assessment and support plans (This last aspect is still in the process of improvement).

4.3 Establishing a secure SGO assessment process to ensure the process is robust and safe for children.

- The 26 weeks court timescales is insufficient time to complete quality assessments taking into consideration that these are permanent arrangements which are life long and involve some of the most vulnerable and traumatised children. There is a need to extend the completion time by at least 12 weeks but have a legal team who support professionals to extend this where required. It should be child led not court led.
- FGC should be used at the earliest point in the process, so family members are identified earlier and the support around these arrangements are agreed and reliable.
- GCSC considers kinship fostering as a positive long-term option. Children's social work teams and Legal generally will not consider this as an option even for a period of time to test and ensure the placement is the best option for the child. Professionals would like this to be a preference in many arrangements.
- Children's views are not taken on board in the decision making and often they have not met or have an established relationship with them.
- The period of transition needs be more child focused and consider the research and knowledge we have about children attachments and trauma.
- There needs to be a contingency plan for the child if the SGO assessment is not positive.
- Children's social workers need to think about the long-term suitability of the placements as opposed to 'they are there now and doing really well'. Children's SW often make a decision about the placement before the assessment is completed forgetting that the carers need to be better than good enough when you consider the needs of the children and the impact of their early childhood adversities.
- Social workers need to be confident and provide evidence to rule the potential carers out in the early stages of stage 1 and 2 viability assessments.
- Improved collaboration between the children's teams, legal and kinship team.
- If the SGO assessment is negative but the child social worker plan is still for an SGO they need to ensure the support plan is robust and mitigates all risks and concerns raised by the assessor who completed the assessment and not ask for the assessment to be changed.

Comment: ***The above information was discussed and taken into consideration. It can be seen necessary and urgent action has been taken by GCC and GSCB in the interim and this review addresses what needs to be done for the future to improve professional practice. (See the Findings and GSCB OV Report Recommendation 1 in Chapter 5 of this report).***

4.4 Additional information of legislation and guidance

4.5 The additional information below, is analysed and taken into consideration as it impacts on the outcome, findings and recommendation and conclusions of this SCR in Chapters 5 and 6.

4.6 Special Guardianship Orders. There is guidance from the President of the Family Division in 2017 which states Judges do not participate in SCRs but where there is learning which may be relevant to the court this can be drawn to the judiciary's attention, with an option to refer the report to the Family Division. This does not apply in this case as Gloucester practitioners were making a presumption an SGO would be authorised in any case. The

Court was guided by and reliant upon the accuracy of a thorough report which looks at the suitability or not of the applicant for the SGO as submitted by the SW which, both this review and the SCIE SCR agree, was optimistic and flawed.

4.7 The Government examined the concerns by holding a review and consultation. The aim of the review was "to protect and enhance special guardianships where they provide the right permanent solution for children and young people, and to identify and remove problems and poor practice in the system" (Investigating Special Guardianship: experiences, challenges and outcomes, November 2014).

4.8 The legislation and guidance has been changed to recognise the requirement for quality assessments which should now include; any harm the child has suffered; any risk of harm posed by the child's parents or other relatives; an assessment of the nature of the prospective Special Guardian's current and past relationship with the child; their parenting capacity; their understanding of and ability to meet the child's current and future needs; their understanding of and ability to protect the child from any current or future risk of harm from the child's parents or other relative and their ability and suitability to bring up the child until the age of 18 years. (Special Guardianship Amendment Regulations 2016).

4.9 An SGO will be given to the person in whose favour the order is made as having parental responsibility for the child. A special guardian may exercise parental responsibility to the exclusion of all others with parental responsibility (although the special guardian cannot consent to the adoption of the child). The SGO will be responsible for all aspects of caring for the child or young person and for taking decisions for their upbringing and future. It allows (as amended by the Children and Young Persons Act 2008) relatives to apply for a residence order or SGO without the permission of the court after caring for the child for one year, instead of three years as was previously the case which was not the case for Megan and the PGM.

4.10 New regulations for SGOs from the Court of Appeal allow Judges some degree of flexibility to allow more time as guidelines express the need to ensure the child's welfare is paramount. The time allowed may well be limited. This review suggests where a child does not know the family member and there has been no previous relationship having only being identified as a family member, then an interim Kinship foster care placement order should be the first avenue, to ensure time is available to test the suitability of the prospective special guardian. Once it is ascertained the family member is suitable then an SGO can be applied for. Both processes need to go through the court to make the decision but having completed a kinship placement and if successful will be evidence to support an SGO and the likelihood of a better outcome for the child and young person, the special guardian and family.

Re A (a child) [2018] EWCA Civ 2240, [2018] All ER (D) 76 (Oct)

Which states "The court must also have regard to the general principle that delay in determining any question with respect to the upbringing of a child is likely to prejudice the child's welfare. The court is required to draw up a timetable to avoid delay in determining the case."

4.11 **SGO Support plans**. SGO Regulations require support plans to be written and shared when a child is placed on an SGO. They are not however shared with universal services, (as in Megan's case her school, nursery and if she had one, her GP practice) who may be unaware of a child's previous LAC status. Universal services might not be in a position to offer support

or be vigilant or focused to changes a child may present and less challenging if concerns are raised or appointments are not kept and requires communication and sharing of such information by all safeguarding partners.

4.12 **Family Group Conference**. A family group conference (FGC) is a decision making and planning forum where the wider family group are consulted and makes plans and decisions for children and young people who have been identified, either by the family themselves or by service providers, as being in need of a plan to safeguard and promote their welfare. This should have been considered at the outset in Megan's case and will form part of the GSCB OV Report Recommendation 1 in relation to identify a pathway process for SGOs.

4.13 **Interim Kinship foster placement.** Legal advice could have been taken to place Megan under an interim Kinship foster care placement to allow time for a full and proper assessment of the applicant PGM. This suggestion which the Independent Author discussed in completing the review with the Head of Service (Permanence) and Gloucestershire Legal Services should be considered as an additional safeguarding level of protection and care. (See GSCB OV Report Recommendation1).

4.14 **Workloads**

4.15 Ofsted's 2016 Annual Report records SW's caseloads were too high. It was prevalent across the Country for caseloads to be high and time devoted to each child to be lower than it should. The SW in Megan's case also felt the caseload was very high. If the suggested SCR OV Report Recommendation is implemented, there will be sufficient time to allow a thorough assessment, which will improve professional practice and alleviate workload pressures for practitioners.

Chapter 5 - Findings and lessons learnt with suggested recommendations for the consideration of LSCB

5.0 This chapter considered the SCIE SCR 2017 initial finding. This SCR review has identified findings and a suggested overarching recommendation from the analysis of information and assessment of professional practice.

5.1 The SCIE findings below have been summarised. A full version of the findings was incorporated in a Gloucestershire CC Action Plan which has implemented learning from the SCIE review.

5.2 SCIE 2017 findings

5.3 The GSCB SCR Overview Report Recommendation 1 below overarches, encompasses and supports the original SCIE findings and Individual Agency Recommendations supplied to GSCB in 2017 with additional observations and action to improve professional practice. The SCIE findings are as follows: -

5.4 **Finding 1:** The decision of a Court to place a child on an SGO is pre-empted by professionals. SGO assessments are less comprehensive and do not meet the same standards as, for example, assessments for adoption. As a consequence, the risks to children placed under an SGO may be higher.

5.5 **Finding 2**: Assumptions made about the benefits of placement within families coupled with timescales within proceedings can mean that the evidence to confirm a placement is safe is insufficiently tested by the court. The behaviour of professionals and courts is mutually reinforcing the use of SGOs in situations where this may not be in the child's best interests.

5.6 **Finding 3**: While there is a requirement under the SGO 2005 Regulations to write an SGO Support Plan they are not effectively used meaning there is no formal process for stepping down a child from a status of 'vulnerable' when looked after to 'previously vulnerable' when an SGO is granted. Relevant universal services are therefore unaware of the change in circumstance.

5.7 **Finding 4**: There is widespread misunderstanding in the professional network as to what different legal orders mean for children and families, leaving professionals sometimes dangerously unsure as to the standing of adults in a child's life.

5.8 **Finding 5**: There is undue tolerance of neglect indicators in some educational and early years settings in Gloucestershire, which is impacting upon timely information sharing and identification of risk and compounded by the way child protection information is held in those settings.
Comment: ***These findings were at the time in 2017 accepted by GCC who have formulated an action plan, through which learning has been and is currently being actioned and implemented throughout the County.***

5.9 The following is the GSCB Overview Report suggested recommendation and findings identified through the analysis of Megan's significant neglect and abuse from information provided to the SCR process. It takes into account the previous SCR. **Recommendation 1** below, is an overarching recommendation to address issues which still remain in relation to

the assessment and application for an SGO and detailed in Finding 1.The finding and recommendation takes into account new guidance and judicial changes to ensure the welfare for the child and young person's best interests is always paramount.

5.10 **GSCB OV Report Findings 2 to 8 below** are recognised themes as evidenced within the SCR which occurred and still require to be addressed to assist and improve professional practice. Some of the themes from the SCR findings have been raised in the 2017 SCIE findings. The GCC and GSCB Action Plan is presently ensuring the learning from both local and national previous SCR's is promulgated. Therefore, these findings although relevant to Megan's review, do not require a further SCR recommendation as they have or are being addressed within the County.

FINDING 1 – Gloucestershire CC Pathway for Special Guardianship Orders

Finding 1 – Pathway application for an SGO

What were the issues for SGOs? This SCR highlights in the narrative of the report, numerous concerns that an efficient and thorough assessment of PGM's application for an SGO was not completed for Megan. There were various concerns raised by practitioners, these include court time constraints to complete the process within 26 weeks, SW's high caseloads, assumptions by some professionals including the IRO that an SGO would be authorised regardless by the courts, pressure caused when a family member is identified later in the court proceedings and the increased practitioner's pressure whereby an assessment was rushed and an over optimistic report was submitted to the court. The report did not fully consider the applicant or her capabilities to provide a stable and long-term loving environment for Megan; a risk assessment of the professional information regarding the lack of bonding between Megan and the PGM, who agreed with the statement and who further admitted the process was being rushed and was not fully explored. This is a failure of professional practice and shows Local and National Policy and Procedures were not followed sufficiently. More importantly, the action taken and the SGO application was not in Megan's best interest. She was failed by professionals as warning signs were present at the application stage and continued when she was later subject to the SGO. There was no attempt by the SW on behalf of GCSC to ask the court for an extension of time.

Once an SGO is set in motion, the special guardian like the PGM, has parental responsibility and does not have to comply with support packages offered and are not subject to GCSC checks which would be the case if the child is a LAC (now referred to as a Child in Care), in a foster placement or placed for adoption. Since the SCIE 2017 review, Gloucestershire have made changes and now carry out four review visits a year to children subject to an SGO. This is good practice and an improvement of what was occurring before, early information suggests this is also being accepted by special guardians. It is, however, not statutory. It is likely if this arrangement had been offered to the PGM, she would not have agreed with the process, due to her non-engagement therefore, safeguards need to be put in place.

What should be considered to address the issues? There needs to be a clear pathway to ensure the issues above do not repeat themselves. To develop a process that will fully assess the viability assessment of any potential applicants for an SGO, thereby ensuring the health and wellbeing of the child or young person. A requirement to establish the special guardian is suitable and has formed a loving family and nurturing bond. An FGC should be held in the early stages to engage with and identify family members for a child or young person. The FGC would explain and discuss the implications and expectation of becoming a special guardian and what can be expected.

Once a family member has been accepted as an applicant, there are two courses of action it is suggested can be considered if the main aim is to apply for an SGO. The first would be if there is an existing and understanding relationship, then the assessment could be completed in the set time or with a slight extension which judges now have the flexibility to allow. In this case the SGO application and report to the court could be made for the process to proceed.

The second course of action, which would be the preference in either case, would be to apply to the court for an interim Kinship Foster Placement when the family member, as in the PGM circumstances, is located late in the process, action which should always be considered at the outset. This will have additional safeguards in place, such as regular safeguarding checks, training, meetings to attend, and support provided which foster carers have to comply with. This will assist practitioners who will have the time to complete an effectual assessment and remove opinions and not assume the SGO will be the obvious outcome in all cases. This action will support the long-term health and wellbeing and ultimately will not only be in the best interests of the child but of the special guardian and other family members. If after a successful kinship placement and a rigorous assessment is completed, then the child's case can proceed to an SGO.

Establishing a clear pathway will assist staff workloads and help alleviate pressure. It may be prudent, whether there has been a relationship between the parties or not, to automatically progress to an FGC, then apply for an interim Kinship foster placement until a satisfactory viability assessment, not subject to time constraints, is completed. If this recommendation is adopted, the first steps for applications for an SGO with the extra levels of safeguarding will be in place to provide a more seamless process. Regardless of the course of action agreed to be taken, there must be supervision oversight when such decisions are in relation to SGO's and long-term placements of children and young people. If this recommendation and pathway was in place for Megan, it is clear from evidence provided to this SCR the PGM's application would not have progressed to an SGO.

Recommendation 1

Gloucestershire CC Pathway for Special Guardianship Orders

GSCB Overview Report Recommendation (1) for Gloucestershire Children Social Care and Permanence Safeguarding Partners

It is recommended Gloucestershire County Council Children Social Care develop a safeguarding pathway for the application of family members for Special Guardianship Orders. The process will include utilising a Family Group Conference and to apply for an interim Kinship Foster Placement to allow safeguarding to remain in place whilst a detailed viability assessment of the prospective guardians' capabilities is conducted. This is whether there has been a previous family relationship or not, as it will ensure the best interest of the child or young person for the long-term period is captured, help reduce staff workloads by relieving time constraints, subject to supervision oversight to make sure the process is effective and in compliance with legislation and guidance.

5.11 The following SCR findings are not subject to recommendations as they are being addressed within the County: -

FINDING 2 – Governance and Supervision

What are the issues and what should be considered? This review has identified concerns as to the function of the governance of CP cases and applications for an SGO. There was no consistent

management oversight, particularly in early interaction with professionals working with the family and in the assessment and report prepared for the SGO applicant PGM.

FINDING 3 - Signs and symptoms of Child Sexual and Physical Abuse and Neglect

What are the issues and what should be considered? There is a need for practitioners to improve their awareness and personal knowledge in being able recognise and identify the signs and symptoms of all child abuse including CSA and neglect. This was a failing by professionals in this SCR, to consider or share the wider concerns for children or young people, a theme in other SCR's. By utilising the Local Authority Neglect Toolkit 2018 this will assist practitioner's awareness in capturing the evolving safeguarding concerns much earlier, in order to signpost the most appropriate pathway, service and support required to protect C&YP. The GCC should ensure there is a clear pathway for children and young people for practitioners to follow.

FINDING 4 – Referrals, SGO assessments, FGC's and sharing information

What are the issues and what should be considered? There was a distinct lack of credible risk assessments in the SCR in particular the assessment for PGM's application to the Family Court Proceedings for the SGO. There was an opportunity to consider risk and the foster carer's view, confirmed by the PGM regarding the lack of bonding between the PGM and Megan. A Family Group Conference in the early SGO process should have been considered. After the SGO was enacted, signs of neglect Megan displayed; the noticeable PGM's attitude and behaviour towards Megan; her failure to engage with professionals and the opportunity for practitioners to consider communicating between agencies and contact GCSC for advice did not occur, was not recognised or considered and were missed opportunities. Furthermore, GCSC did not make other agencies aware of Megan's vulnerable background that she was a previous LAC. An earlier professionals meeting or strategy discussion should have been held which would have captured the wider dimensions of Megan and her home life and would have recognised Megan was also not registered with any GP Practice whilst living with her PGM. Regular communication and information sharing between agencies may have resulted in a better outcome and different action being taken earlier for the protection of Megan's health and welfare.

FINDING 5 – Child focused and capturing the voice of the child

What are the issues and what should be considered? Megan's voice was not substantially heard or captured in the 2017 SCR which, may have been due to limited access to Megan's account given to police for the criminal investigation. When Megan was spoken to by practitioners about being hungry on several occasions, being cold with blue lips and concern for the clothing she wore, these concerns were not progressed satisfactorily. School staff informed the Designated Safeguarding Lead and it was left for school staff to raise the concern directly with the PGM, which it is suggested, her response was dismissive. Practitioners should have pursued these possible safeguarding concerns further and displayed professional curiosity, a finding in this review.

The voice of Megan was therefore not effectively captured at the time considering the subsequent disclosures she made, to police and her articulation of serious events she endured within PGM's home and were missed opportunities.

FINDING 6 - Record Management

What are the issues and what should be considered? Agency submissions indicated a deficiency in some record keeping as outlined in the narrative of this report, a persistent concern in previous local

and national SCRs. There is a need for agencies to have robust record keeping and management systems in place and to make enquiries where there are information gaps. In Megan's case, the nursery and school did not have any GP Practice details, background history of Megan and her family dynamics.

FINDING 7 – Learning from SCR's

What are the issues and what should be considered? All safeguarding agencies concerned in the serious case review must remind staff of the requirement to make themselves aware and to comply with the learning from previous SCRs. The NSPCC,[4] on their website every year, publishes recent learning from SCRs which highlights similar learning relevant to the 2017 and this review and action taken to be taken to inform professional practice. This finding is still relevant to this day.

FINDING 8 – Professional curiosity, optimism

What are the issues and what should be considered? There was a consistent lack of professional curiosity and scrutiny displayed in the assessment of child protection concerns apparent throughout the SCR for Megan. There were missed opportunities for supervisors and practitioner's professionalism to consider and capture the wider picture of possible neglect concerns which were evident in Megan's presentation in her educational setting. There was too much optimism shown by the SW and IRO when conducting the SGO application of PGM's capability to care for Megan. "Think children first" is an emphasis on the priority of a child's welfare over parents and guardians with professional curiosity and disguised compliance awareness and training.

Individual Agency Recommendations

5.12 The participating agencies and organisations to the SCR for Megan have identified learning for their respective agencies during the 2017 SCR process. Their recommendations have been agreed by Agency Heads of Service and Senior Management and form part of the current GSCB SCR Action Plan. This SCR has reviewed the action plan, it is current, relevant and appropriate. Action has been or is being taken to ensure learning is being promulgated within the County.

[4] NSPCC Yearly audit of published SCRS.

Chapter 6 – CONCLUSIONS

6.0 This SCR Overview Report for Megan is GSCB's response to establish future learning to enhance child protection safeguarding and professional practice within the County and beyond. Findings from the previous SCIE report have been implemented by GCC since it was completed in 2017. This review however has considered the original findings and learning implemented and identified the need for a dedicated pathway for the assessment of family members who are applicants for consideration for an SGO. If the proposed SGO Pathway recommendation had been in place, the PGM it is reasonable to suggest, would not have been found suitable due to the concerns raised at the time by the foster carer, health visitor, Court Guardian and by the PGM herself. (See GSCB OV Report Recommendation 1 in Chapter 5).

6.1 If endorsed, it will ensure another level of safeguarding for C&YP and time for practitioners to conduct thorough SGO assessments not subjected to a 26-week timeline, to complete. At a recent case in the Court of Appeal, 2018 (see Appendix 1) it was recognised that the concerns when a thorough assessment of a family member is identified for consideration late in the day, where an effective assessment cannot be made in the best interest of the child. Judges now have flexibility to consider extending the timeline, but this it is suggested will be limited and may still be insufficient time for a thorough and robust assessment being carried out.

6.2 The proposed recommendation suggests on all occasions the subject should become an interim Kinship Foster Care placement, not subject to any deadline, which would ensure where there has been no previous relationship, it allows sufficient bonding time and consideration for the long-term care of the child. The pathway should be followed to remove the need for the temptation to rush an assessment, if high SW caseloads were to persist, before an application for an SGO is made.

6.3 The review has ensured the voice and the life of Megan is captured whilst living with her PGM, her family and acquaintances in the home. Megan's story of the cruelty and abuse she had to suffer as a result of being placed with her PGM under an SGO as detailed in Chapter 3, Period 4, is a travesty and needed to be recorded. What occurred to her, the physical and emotional abuse she suffered was despicable, confirmed by the custodial sentences given to the defendants. This was a significant failing for Gloucestershire County Council Children's Services as the professional practice of placing Megan in the PGM's home was an unsound decision. This is not a burden to be placed upon the judiciary in this case. It was the insufficient and over optimistic quality of the report, which did not reflect all the worries of the PGM, absent from the information presented to the court on behalf of GCC. A notable absence of supervision to assess the quality of the SW's final report and the assessment, was not a failsafe in Megan's case, which it should have been.

6.4 Predictability and preventability

6.5 The initial abuse may not have been predicted as a result of the SGO placement. The requirement however to carry out a through and tested SGO assessment to consider all risks for such an important long-term decision for a child and young person cannot be over emphasised, *'if it is done correctly in the first place, in the best interests of a child or young person, it will help to determine the securement of a loving home environment for the child, the guardian and the family.'*

6.6 An SGO assessment, which did not consider warning signs of non-bonding and the later failure within her nursery and school to recognise and act upon the sign and symptoms of neglect, means the events described in this report should have been preventable. As outlined in the narrative of this report, there is significant learning for practitioners from the first SCIE SCR in 2017 and within this SCR.

6.7 Opportunities to intervene prior to abuse

6.8 There were missed opportunities during the SGO application process for PGM of possible concerns for Megan. There were further concerns once Megan became a subject of the SGO within in her nursery and school setting and contact with practitioners. Clear signs and symptoms of neglect were not recognised and there was a lack of professional curiosity, communication and sharing the information between agencies, all findings in this review.

6.9 Engagement with professionals

6.10 The SCIE SCR 2017 report adopted and held interviews and practitioner events, and these have not been replicated in this updated Overview Report. To identify underlying concerns and professional practice from 2011 until the present day for this review, the Independent Author met with two key practitioners, the Head of Service (Permanence) and a representative from Gloucestershire Legal Services. It was to establish - What was professional practice in 2011? What was the professional practice up to 2017? What is in place now and what still needs to be done? (The information was analysed in Chapter 4 and within the Findings and GSCB OV Report Recommendation 1 in Chapter 5).

6.11 Local and National Safeguarding Policies and Procedures

6.12 The SCR identified a requirement for practitioners to have the knowledge and awareness of Local and National Safeguarding Policy and Procedures. There is a need to ensure compliance and the requirement to utilise the Gloucestershire Neglect Toolkit 2018 which is being rolled out within the County for practitioners to be able to recognise and act upon the signs and symptoms of neglect and abuse.

6.13 Culture and Diversity

6.14 Culture and diversity was not an issue identified within this SCR for Megan from information provided to the review.

6.15 Previous SCR's

6.16 The bibliography in Appendix 1 incorporates previous SCRs relevant to this SCR as well as legislation, guidance and research. There were numerous indicators of neglect, consistent with this case contained within the NSPCC data base from previously published SCR's.

6.17 Professionals Overriding Responsibility

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

[5] Working Together to Safeguard Children 2015 - HM Government March 2015

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

Comment: ***It is clear standards of child protection fell short of this expectation during the scoping period of this review. There have been great strides to ensure learning from 2017 has been recognised and applied. The fundamental responsibility for safeguarding and promoting the welfare of all children and young people was not previously consistently followed. Gloucestershire CC and agencies to the review have implemented learning to ensure lessons are learnt. This review however promotes an overarching SGO pathway recommendation to improve the process of application and assessments, a fundamental failing in Megan's case.***

6.20 Overview Report submission to the GSCB

6.21 Neglect, and the voice of Megan, should have stimulated a more robust response and assessment found lacking in this review. It was only when there was the significant presentation in hospital of numerous injuries, poor health and an underweight Megan when professionals took decisive action to protect her. This review has identified a number of findings where practice was not to an acceptable standard and is a repetition of not only the SCIE 2017 findings but from other recommendations Gloucestershire CC are aware of and are in the process of developing and implementing learning within the County in accordance with their current GSCB Action Plan. Although there has been positive action taken in the intervening period since 2017, this review believes the pathway recommendation for SGOs and if successful in the application, may be a stimulus for the process to be adopted nationally, driven by Gloucestershire County Council.

6.22 In October 2015, new guidance was issued by the Association of Directors of Children's Services (ADCS) and the Children and Family Court Advisory and Support Service (Cafcass) namely,'*The Assessment of Specials Guardians as the Preferred Permanence Option for Children in Care Proceedings Application.'* This follows concerns that children had been placed at risk through an SGO being made without sufficient consideration of the placement's long-term viability which, as a direct result, avoidably increased the risk of placement breakdown or the risk of immediate and significant harm. The guidance notes that many of those placements had been arranged at a late stage in care proceedings without adequate time to carry out a suitability report to safe minimum standards. This SCR is of the opinion the risks and findings referred to in this guidance reflects the situation that occurred within the SGO assessment process for Megan which, the SCR aims to address.

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

[6] Children Act 1989 and 2004.

Appendix 1- Bibliography

Key legislation, regulation, guidance and research (See also references within the narrative and the footnotes of the report).

Legislation

- The Children Act 1989, 2004

Regulations

- Care Planning, Placement and Case Review (England) Regulations (2010 as amended)
- The Fostering (England) Regulations (2011 as amended)

Statutory Guidance

- The Children Act 1989 Statutory guidance and regulations: Volume 2: Care Planning, Placement and Case Review.
- P-S (Children) (2018) EWCA Civ 1407
- The Children Act 1989 Statutory guidance and regulations: Volume 4: Fostering Services *Re A (a child) [2018] EWCA Civ 2240, [2018] All ER (D) 76 (Oct)* Family and Friends Care: Statutory Guidance for local authorities.
- Re S (a child) (adoption order or special guardianship order) [2007] 1 FLR 819
- Re R (a child) (special guardianship order) [2006] EWCA Civ 1748, [2006] All ER (D) 299 (Dec)
- Family Justice Council: Interim Guidance on Special Guardianship—24 May 2019
  Re P-S (Children) [2018] EWCA Civ 1407, [2019] 1 FLR 251
- Statutory Instrument: Special Guardianship (Amendment) Regulations 2016 No.111 amends the Schedule to the Special Guardianship Regulations (2005) ("the 2005 Regulations").

Previous SCR's

- NSPCC SCR database.
- Previous Gloucestershire SCRs: -

    1. SCR Mrs Spry published in 2005. This was a case where the children fostered by Mrs Spry were seriously neglected.
    2. SCR Abigail published in March 2014. There are similarities in Abigail's experience with numerous indicators of neglect.