Serious Case Review (SCR) Briefing

Practice Briefings

Children of Family Y

M along with his two younger brothers and his younger sister, were known to Children's Social Care (CSC) since 2008. They were all victims who suffered from significant and chronic neglect over many years.
The elder of the four children, M committed intra-familial Child Sexual Abuse (CSA) on his three younger siblings on numerous occasions over a period of time from 2010 to 2016.

The SCR Findings

1. Referrals, risk assessments and sharing information.
All agencies must comply with national and local Safeguarding policies, procedures and guidance in relation to referrals, risk assessments and the requirement to *share* child protection safeguarding information or concerns.

When there is a disclosure of an allegation of a crime which impacts on a child or young person, an immediate referral must be made for a strategy discussion, to consider initiating or planning whether a Section 47 Investigation is required.

This is in conjunction with any criminal investigation in order to identify the most appropriate action required to be taken to protect and support a child or young person and to preserve potential evidence.

> "the home environment conditions were filthy and the children often went hungry, there was little or no supervision by any grown-up, including their elder adult half- siblings, with no boundaries or rules in place".

2. Governance and supervision
Escalation policies must be used where there is a disagreement as to process or course of action taken.

An improvement of supervision, including supervision of supervisors, in single assessments, chairs of safeguarding meetings, including CP Plans and CIN meetings and child protection cases, to ensure the wider picture of a safeguarding case are captured and acted upon before closure of a referral, safeguarding risk assessment or meeting, consideration as to the causation of presenting concerns must have considered CSA, Neglect and all other signs and symptoms of abuse before closure.

Identifying high-risk cases with historical concerns (regardless of the length of the intervening period) with repeating safeguarding concerns, are scrutinised by senior management and referred to the Head of Service if necessary.

3. Recognising signs and Symptoms of child sexual abuse and neglect
All safeguarding partner agencies must ensure staff are made aware of the signs and symptoms of CSA and know what to do if they are seen or suspected.

Useful links:

1. https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-sexual-abuse/
2. https://seriouscasereviews.rip.org.uk/lscbs-new/#lscb_introduction
3. https://www.csacentre.org.uk/ 4. https://www.proceduresonline.com/swcpp/

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> *"Soiling is a possible sign and symptom of CSA which professionals did not recognise or consider in their interaction and assessments with the children"*

Staff must utilise the Neglect Toolkit in order for practitioners to identify and capture evolving safeguarding concerns at a much earlier stage.

4. Professional curiosity

It is recommended all Child Protection Partners and relevant voluntary organisations within the LA area assure the Safeguarding Partners that staff have supervision oversight on their child protection safeguarding cases, to ensure there is professional curiosity displayed, and not a propensity to have an over optimistic view of compliance by parents and carers with disguised compliance challenged where displayed.

> "There was no professional curiosity displayed and assessments were lacking in quality and depth".

5. Child Focussed / Voice of the Child.

It is recommended all Child Protection Safeguarding Agency Partners and voluntary organisations within the local authority area, assure the Safeguarding Partners they have reminded their staff of their

duty in safeguarding cases to ensure the voice of the child is captured and are focused on the experience and impact on children, as identified in learning from previous serious case reviews

6. Legal Proceedings

It is recommended the Safeguarding Partners require CSC and Legal Services to agree regular communication and updates on the progress of family cases in legal care proceedings. This is in order to keep any delay to a minimum and for interested parties to the proceedings to receive regular information of the progress of the case.

> "The children were being left alone to look after themselves"

7. Learning from SCRs

It is recommended all Child Protection Safeguarding Agency Partners and relevant voluntary organisations within the local authority area assure the Safeguarding Partners they have informed all supervisors and staff of the need for all practitioners to have the required knowledge and awareness of recent learning from previous serious case review publications, in order to ensure their decision making and actions to safeguard children and young people that similar concerns are not being repeated.

8. Police Protection

The Police IMR identified that police officers could have utilised Police Powers of Protection (PPP) on several occasions when the children were found in squalid unhealthy condition within the family home. It was suggested this may be due to a lack of knowledge by some police officers of their powers and may require additional training.

This was not systemic however, as police officers on other occasions did show professional scrutiny and appropriately invoked PPP.

Useful links:

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9. Was Not Brought Policy
Partners adopt the more appropriate terminology of 'Was Not Brought' (WNB) instead of 'Did Not Attend' (DNA) which unjustly places an emphasis on a child when it is the parent or guardian who does not bring a child or young person to an appointment.

All safeguarding partners have suitable policies in place if a child is persistently WNB to appointments. There must be supervision oversight to consider if this indicates harm to a child and the details recorded within the child's chronology.

> "The mother was displaying disguised compliance traits and was often untruthful to professionals".

10. Child Medical Examinations
It is recommended Children's Social Care, the Police Service and Care Services, within the local authority area, assure the Safeguarding Partners there is an agreed memorandum of understanding in the correct procedures and action to be taken for the completion of children and young people's medical examinations.

11. Multi-Agency Chronologies
Child Protection Safeguarding Agency Partners and relevant voluntary organisations within the local authority area to assure the Safeguarding Partners that their staff complete background chronologies on their case files on children and families subject to child protection enquires, in order that practitioners have the fullest information available to make informed decisions of the most appropriate action to be taken.

12. Record Management
Each agency to ensure their recording keeping and management systems are robust, comprehensive and up to date.

> "The professionals involved in this SCR acknowledge that M's representations were as a consequence of what happened to him".

Professionals must ask themselves. Would I leave my children in circumstances M and his siblings faced on a day to day basis, suffering neglect, worrying health concerns and living in an appalling uninhabitable family home?

From the information this SCR has obtained, the answer must be a categorical 'no.'

> "In conclusion the neglect, health concerns, poor home conditions and missed CSA (from 2012) should have been both predictable and preventable with the amount of contact and interaction with professionals from 2008 until the disclosure (neglect continued after the CSA disclosure until 2017) when the children were all placed in foster care".

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Details

M is both a victim and perpetrator of intra-familial child sexual abuse. Professionals for eight years failed to take effective action and there were missed opportunities to ensure the children were appropriately safeguarded and protected.

M, along with his younger brothers and sister had been known to Children's Social Care (CSC) since 2008. They were all victims who suffered from significant and chronic neglect over many years.

The elder of the four children, M committed intra-familial Child Sexual Abuse (CSA) on his three younger siblings on numerous occasions over a period of time from 2010 to 2016. He pleaded guilty to all the offences.

Concerns were raised of extremely poor conditions of the home and serious neglect issues. The mother consistently failed to provide care and support for the children; even with agencies providing family support.

The parents of the children were estranged and had not been in a relationship for many years prior to the disclosure of CSA; however both parents were charged and convicted of neglect offences against M his sister and two brothers.

Agencies did not respond appropriately to the conditions documented.

Each CSC referral resulted in an initial assessment (IA) but there was no intervention offered to the family by CSC.

The concerns that led to these referrals focused on neglect and very poor home conditions. When the social worker (SW) visited the home, Mother made reassuring statements about improvements.

All children were placed on a Child Protection Plan (CPP) on two occasions under the category of neglect

The children were initially seen to be in good health although living in a poor environment but it is evident the voice of M and the other children were not effectively obtained to understand their perspective of life.

The first CPP was closed despite the circumstances of the home conditions and the neglect of the children still being present. There appears an optimistic approach by professionals that Mother would improve and sustain improvements which she never did on any occasion.

Two of the children, at School, were reported to be soiling themselves on a daily basis and both had persistent head lice.

The mother was required on several occasions to make appointments with the family GP regarding encopresis (soiling) and also with the dentist as the child had severe dental decay. No appointments were made.

One sibling was referred to an incontinence team but was not brought (WNB) to the appointments by the Mother.

The lack of rules and the neglect M suffered were principal reasons he behaved as he did, to abuse his younger siblings.

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