Local Child Safeguarding Practice Review

Family N

May 2021

1. Background

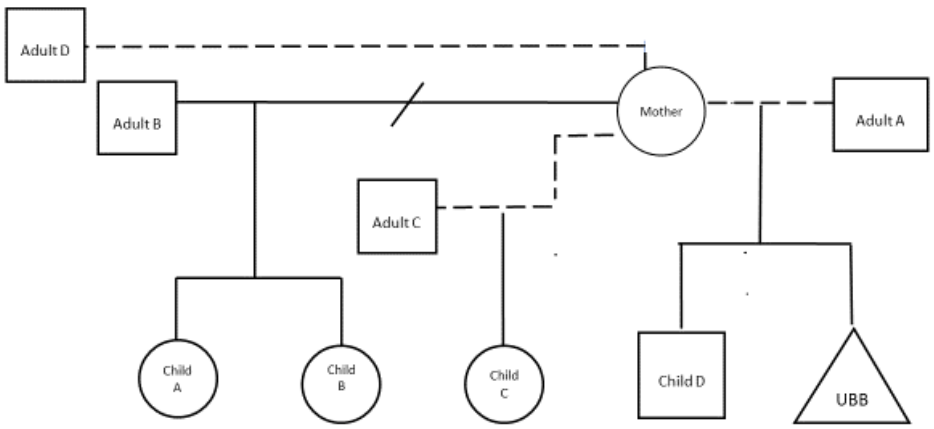
This Local Child Safeguarding Practice Review (LCSPR) was commissioned following a 999 call to the Police in June 2020. A male adult (Adult A below) was found holding a knife to his partner's (Mother below) throat. She had arrived home and witnessed Adult A sexually abusing Child A. Child B had called the Police. Following Adult A's arrest Child A disclosed that she had been sexually abused by Adult A on more than one occasion. All of the children were subject to a Supervision Order at the time.

The LCSPR builds on the work carried out in the rapid review held after this incident was formally notified and through a practitioner event held with those involved to explore the issues further. That event was facilitated by Mark Gurrey, Independent Scrutineer of the Safeguarding Vulnerable People Partnership (SVPP) and he presented this report to the safeguarding partners for agreement and endorsement.

Family Make-Up

Child A	aged 13 at the time of incident
Child B	aged 12 at the time of incident
Child C	aged 6 at the time of incident
Child D	aged 1 at the time of incident
UBB E	Unborn at the time of the incident
Mother	Mother of all the children
Adult A	Mother's Partner and Father of Child D and UBB E
Adult B	Ex-husband of Mother and Father to Child A and Child B: deceased
Adult C	Father to Child C
Adult D	Mother's Former Partner
Child J	Older sibling, now 18, son of Adult B and sister to the two eldest girls who lived with his grandmother throughout this period and is not part of this review.

Genogram



2. Case Summary

This summary sets out the circumstances leading up to the incident in June 2020.

The family moved into Wiltshire in 2009. The early contact with the family was via the Wiltshire Young Carer's Service who worked with Child J in relation to his father, Adult B who had a life-limiting lung condition. The service later worked with Child A and Child B because of their experiences of caring for their mother as a consequence of both her alcohol abuse and mental health problems. The service maintained some involvement when the girls went to live with their father but this was stopped when he died and they returned to their mother.

In October 2017, there was a domestic abuse incident between Mother and her then partner Adult D. An Initial Child Protection Conference was held and children A, B and C were made subject to Child Protection Plans under the category of emotional abuse.

In January 2018 Mother arranged for Child A and B to live with their father, Adult B, and for Child C to live with her father, Adult C and her paternal grandparents, whilst Mother remained in the relationship with Adult D. This appears to have been a decision Mother took herself and apparently told the children they were moving because she did not love them anymore.

In February 2018 at a Review Child Protection Conference the decision was made for the children to step down to child in need status as the risk had reduced as a consequence of the children living with their respective fathers. In April 2018 the children's case was stepped down to family support.

In July 2018 Mother entered a relationship with Adult A. She sought police disclosure under the domestic violence disclosure scheme (Clare's Law) which provided her with information regarding his past domestic abuse including violence and coercive control.

She was also informed about previous child sexual abuse allegations. Adult A was subject to a police investigation and charged in 2013 with sexual offences against his daughters, then aged 6 and 8 years (not subjects of this review). The matter went to Court and was heard in 2014. The trial resulted in a hung jury necessitating a second trial and this was stopped due to the Judge dying before the conclusion of the hearing. The third trial found him not guilty.

This information did not persuade Mother that Adult A was a risk to her children.

In August 2018 the case was closed as the girls remained living with respective fathers, having contact with mother only.

In October 2018 Mother removed Child C from her father's care and stopped contact between her and her father following a dispute between Mother and Adult C.

In December 2018, a referral was made to social care by midwifery when they became aware that Mother was pregnant with Child D based on their knowledge about the history of domestic abuse and alcohol abuse. At that point Mother was declining to give details of the father of the unborn child.

As a consequence of the referral, a single assessment was completed and this led to the convening of an Initial Child Protection Case Conference in February 2019. By this point, it became known that Adult A was father to the unborn child. The conference decided to make Child C and D subject to child protection plans under the category of emotional abuse.

Mother and Adult A did not engage with the protection plans and in May pre-proceedings were initiated.

In September Adult B, father to Child A and B, became ill and died later that month as a consequence of his lung condition. The children were returned to the care of Mother – their grandmother did indicate a wish to keep them both but this did not happen. On their return to the family, both children were made subject to CP Plans along with their siblings.

Pre- and Post-Care Proceedings

The lack of engagement and resistance to working with any of the safeguarding agencies and the lack of cooperation with the child protection plans and the pre-proceedings work led to the local authority issuing Care Proceedings in November 2019. Their care plan was for (at least) interim removal of the children from their Mother's care.

Court-ordered parenting assessments were commenced, carried out by the Specialist Contact and Assessment Team. Adult A refused to engage with the assessment.

Throughout the work thus far, Mother had been reluctant to engage with any support for either her use of alcohol or the offer of help with the domestic abuse she had experienced and was still experiencing. However, following a positive test for excessive alcohol she then stated that she would contact Turning Point and the Nelson Trust. She self-referred herself to the Nelson Trust, an agency designed to help people address trauma and overcome addiction, stating she wanted to work on domestic abuse, on relationships and on alcohol addiction. She completed an assessment with them however limited work with them was able to take place before the incident in June.

She was also referred on a number of occasions to Splitz, a domestic abuse support service, but only responded positively three times and after each of these occasions she disengaged and refused further follow-up.

Mother continued to deny that Adult A was a sexual risk to her children.

The parenting assessments were filed with the Court in March 2020. The assessments stated that neither Mother nor Adult A could be considered as carers for the children. They concluded that Mother could not protect her children from the sexual risk Adult A posed as she did not believe it existed; she continued to minimise the domestic abuse concerns and could not protect her children from these; and that her alcohol use and its impact upon her parenting was a continuing concern.

At the same time as the assessments were being submitted, Mother confirmed that she was pregnant again by Adult A.

Throughout this period, Adult A was supposedly living away from the family with limited contact with either the Mother or the children. However, the suspicion was that there was considerably more contact than either adult will acknowledge. There was evidence that he was often in the home and although the status of the relationship was challenged by the Social Worker, it remained explicitly at least, unclear.

The final hearing was in April 2020 and the agreed care plan stated that there would be a 12-month Supervision Order and that Adult A should not have any contact with the older children and that his contact with Child D should be supervised by the paternal grandmother (as the view was that Mother could not be relied upon to do that safely). This plan was supported and endorsed by the guardian.

By this point, the first national lockdown was in place in response to the Covid 19 pandemic and this continued up to (and beyond) the incident described in June 2020. During this period, agencies persisted in maintaining contact with the children through telephone calls. When the Social Worker did try to make a home visit they were not allowed into the house. Adult A continued to demonstrate obstructive behaviour and raised concerns about social work visits and social distancing. He declined a health visitor home visit and tried to dictate when contacts with professionals could take place. His involvement in meetings changed after the supervision order when he became markedly more aggressive and non-cooperative. He refused an assessment in relation to unborn baby, but this proceeded anyway. He made a number of complaints and informed professionals that he was recording all conversations and had placed cameras at the Mother's home.

There is considerable evidence that during this time, all agencies were keen to maximise their involvement with and oversight of the children and Mother. However, although there was regular phone and video contact with a number of agencies, professionals would not necessarily have known who else was in the room nor could they be completely assured the children were safe and well. For the bulk of this period, the children were not in school, despite encouragement to the contrary, so there was not the normal daily supervision of their well-being.

There is evidence that both Adult A and Mother used Covid 19 as a reason for not allowing professionals in the home or the children to return to school; in the light of Adult A's history of controlling behaviour there was a concern that this enabled him to further isolate the children and Mother from wider family and support services and evade questions and scrutiny.

When spoken to, the children reassured all agencies that they were well and not at risk. Notably, however, there were two instances during this period when Child A self-harmed and whilst relatively minor in terms of physical impact it nevertheless was of concern. Both instances were followed up but, due to the restrictions around at the time, it was difficult to do so as thoroughly as might normally be the case. Mother was asked to pursue concerns with her daughter.

In the 10 days leading up to the incident all of the children had been seen face to face and or spoken to by agencies.

In June Child A called 999. Adult A was found to be threatening mother with knife to her throat, whilst she was holding Child D. Adult A was arrested and Child A disclosed sexual abuse by Adult A over the previous 4-6 weeks on up to 3 occasions, including rape.

Adult A has since been sentenced to 23 years in prison.

3. Practice Review Process

This latter section was completed through a multi-agency practitioner event attended by all those who had been active in providing a service to this family and these children over the last 1-2 years (longer in relation to the schools and some health provision).

The rapid review completed for this case identified the following issues as needing further exploration and these were pursued in the practitioner discussion.

- How can the safeguarding system respond when work is stuck; when there is evidence of what has become known as disguised compliance; when children are not wanting any engagement nor evidencing any concerns but where the risks remain real and substantial. When these circumstances are presented to Court, what is it reasonable to expect from the judiciary, from Cafcass and from the legal process?

- Understand how professionals perceive their role and responsibilities in relation to care planning and when to escalate concerns

- Understand how court rulings can influence the continuing risk assessments by professionals working with children and families

The section starts with a brief overview of the children.

Child A – is described as 'quiet but quirky' and can be led by Child B – she is more open to conversation when on her own. She understands why they were removed but struggles with a sense of responsibility for what has gone on in her family. She has junior idiopathic arthritis and as a consequence has missed time at school.

Child B – is a bright and articulate girl but also quite closed. She is reluctant to engage with professionals outside of school but will generally talk to adults in school. She loves music and cooking; the latter interest was something her father taught her and she was described as a 'daddy's girl' and she found it very difficult when he died. She engaged with Young Carers at that time.

Child A and B are placed together and have a great relationship with their foster carer.

Child C – is a happy and confident little girl. Again, she is very closed to professionals but will talk to her Emotional Literacy Support Assistant (ELSA) on a weekly basis at school and she has referred to the incident in June. She will often write things down or communicate through drawing. She is now living with her father and grandmother; she

has always wanted to live with them and was always extremely pleased to see them but would never voice it when living with her mother.

All three girls are well presented, polite and work hard at school. Child C is living with her father, Adult C supported by her paternal Grandmother.

Child D – was a happy and contented baby. He gained weight well and continued to meet all his developmental milestones. He was seen monthly at a drop-in clinic and the interaction between him and his mother was always positive. He is a very lively little boy but also likes routine. There is a low-level concern about speech development as he does not mimic sound.

Child E – was unborn at time of incident. She is now doing well and is placed with Child D.

4. Analysis of Practice

There is a significant and complex history associated with this family and risks were known and understood by agencies. Good practice was evident in relation to multiagency working and information sharing, Adult A's grooming behaviour was identified and challenged and regular virtual contact and some face-to-face visits were maintained during lockdown by different agencies.

The following key themes were explored in detail as part of the CSPR process.

Care Proceedings - The decision to seek supervision orders, especialy in light of the adverse parenting assessment needs further explanation. The historical sexual abuse allegations against Adult A were unproven and indeed he had been acquitted in the criminal trial. Mother continued to deny any domestic abuse and whilst there was evidence of alcohol misuse (via hair strand tests) in and of themselves they would not have established threshold evidence for removal. In addition, the children were not only not disclosing any abuse or concerns, but they were also clear about wanting to be with their Mother. Mother was seen to have very warm relationships with them all and there was much about their day-to-day care that was positive.

It was the view of the local authority, supported by the guardian, therefore that a care plan for removal would fail and the supervision orders were the only viable disposal available to the Court based on the evidence presented, the parenting assessment notwithstanding.

It is the view of children's social care, in the paperwork submitted for both the rapid review and this report, that this should have been escalated to senior managers. This review supports that decision. Escalation would have offered the opportunity for senior managers to examine the evidence to be presented and give them an opportunity to explore whether a presentation to the court for removal was an option. They could also have led a discussion with Cafcass – who were supporting the local authority position for supervision orders – at a more senior level and, if necessary, a readiness to present directly to the Court. Cafcass' report for this review indicated some concern that the risks to these children had not been fully explored and assessed and the fact that the evidential base for removal was too weak was accepted too readily.

Another key lesson that emerged from this review is that many of the involved agencies are not sufficiently sighted on or knowledgeable about many of the aspects and terminology associated with care proceedings: the nature and type of the various hearings; the orders available to the Court; the obtaining (and losing) of parental responsibility and the weight and nature of evidence required are all areas which require greater shared knowledge and information sharing. This is covered in the Recommendations.

Working with Resistance and 'Stuckness' – one other key feature of this case and of this review has been the difficulties the professional network experienced in positively engaging with the family; Adult A worked relatively successfully to keep a distance between the agencies and the family. This is described further below but he was

aided, either deliberately or unwillingly by Mother who maintained her position that Adult A presented no risk. Yet there was within a number of the professionals a consistent nagging feeling that all was not alright. This sense that concerns remain is important (see below) and will be rooted in experience and expertise. Given the history, the likelihood that these children were exposed to or experiencing abuse was strong and it was right that all the agencies continued to maintain a focus on them.

This is not uncommon in safeguarding practice – working with families where there are strong and legitimate reasons to believe the children are at risk but where the evidence is difficult to marshal and the family is uncooperative. This is often described as 'disguised compliance'. This is not a helpful or necessarily accurate term - the problem is better stated as a lack of compliance and nor does it do enough to capture the complexities of what might be behind that lack of compliance.

The practitioner event discussed the reality of working with a family who sought to keep agencies at arm's length and the following was identified as useful learning to share across the agency network:

- Persistence and tenacity, as demonstrated in this case, are essential. The system cannot and cannot be allowed to give up, even where pressures of other work might intrude
- 'Gut feelings' are important and should be acknowledged and explored within the supervision process. They may turn out to be baseless but the starting point should always be to acknowledge they exist and that they will have come from somewhere and will have some legitimacy. They are different from assumptions and partially or poorly evidenced views and presumptions and it is the role of supervision to help isolate one from the other. Change of worker can be a risk here – 'gut feelings' need to transfer with them.
- Consistency of staff within the professional system is important – maintaining case narratives, ensuring key historical events are not lost and sustaining a continuity of input to the family are all crucial in these instances and breaks in consistency and continuity can lead to a loss of the tenacity and persistency identified above
- Maintain input and discussion into child in need meetings, core groups and case conferences. These formal meetings are essential in maintaining the focus on the core risks and concerns
- These meetings are also important in ensuring agencies are understanding the risks in the same way, are presenting to the family in a consistent way and that the family experience the partnership work as united.
- When those involved believe themselves to be stuck in their work with a particular family, then they should openly and proactively seek external group supervision to help explore the issues further. The source of supervision may vary and could come from one of the involved agencies or from one uninvolved with the family (CAMH services are often a positive resource). This is particularly true when, as in this case, the involvement is driven through the child in need process. Unlike child protection planning, children in need does not benefit from external and off-line chairing and indeed it is usually the social worker who is the lead professional, the chair and the minute taker for these meetings and that does not lend itself to a reflective and multi-agency analysis of the case.
- One of the outcomes of such supervision and an option anyway available to staff is to consider mediation between the family and the network. Each can get stuck in their own positions and there are times when external support and challenge to those positions is both helpful and necessary. This is particularly the case when removal of children is being considered as the only available option left to the professionals.
- Listening to and understanding the wishes and feelings of children is not the same as doing what they want. In this instance, the children were clear in wanting the agencies to 'leave them alone' – that should not (and was not in this instance) be allowed to be given too much weight in the light of other features and concerns (see below)

Working with Child Sexual Abuse – sexual abuse, probably more than any other form of abuse, is often silent and hidden. For a variety of reasons, children do not disclose sexual abuse in the same way they might physical harm and neither is there always medical evidence to support the claims of abuse. This case serves as a useful reminder to the system about the behaviours of abusers which often include:

- exploitation of the child's sense of embarrassment about the abuse

- threats to the child including the threat of them being taken away
- threats to harm themselves including the threat that they might be taken away
- threats to harm their mother
- describing it as a special relationship which others would not understand

At this stage it is not yet known which of these or which combination of these (or other) techniques Adult A used with the children. The outcome was however effective and none of the children were able to say, even through hinting or non-verbal behaviour the fear they must have experienced and their obvious wish to be made safe, further hampered by lockdown and the majority of contact with agencies being virtual throughout this time. Children A and B have still not really spoken about their experiences and are consistent in their defence of their mother.

Direct work with children is required that starts from a position of understanding these various silencing methods and seeks to allow children to talk about their daily experiences and their relationships with those around them, delivered via a supportive and neutral approach. Trying to get children to confirm the professional's suspicions about what is happening to them cannot be too direct (as it appeared to be in this instance) and can be counterproductive in pushing the children further into silence.

In addition, and a matter of discussion within the practitioner event, the behaviour of Adult A with the professional network is consistent with how some abusers behave in an attempt to obfuscate and to keep the system both at arm's length and to seek to exert some control over it. He was often experienced as aggressive and threatening, tried to manage meetings by declaring who could and could not be there, made frequent complaints and used recordings of meetings and use of cameras as a threat. The opportunities provided to him by the Covid pandemic added to his arsenal and gave some legitimacy to his wish to maintain a distance from those seeking to keep the children safe.

5. Recommendations

1. That the issues set out above will form the basis of a practitioner briefing to go out to all agencies within the SVPP network. This briefing to focus on:
    a. How sexual abusers can silence children
    b. Patterns of sexual abusers' behaviour
    c. Dealing with work that can get stuck

   That as the leaders within SVPP, we will ensure that the messages within this review are disseminated throughout their organisation.
2. That we will ensure that these issues will be built into the SVPP workforce development programme and are used to inform the content of future training within the partnership.
3. That we will ensure the (final) draft 'Child in Need (Section 17): Multi-Agency Guidance' is agreed and disseminated.
4. That as the leaders within SVPP we will explore the extent to which supervision is available to their staff and the potential to establish a group supervision approach to dealing with stuck child protection work and we will free up our staff as needed and as appropriate to act as group supervisors to practitioner groups who seek outside consultation and assistance in moving work on. We are aware this offer already sits within the 'SVPP Case Resolution Protocol' and we will ensure this is recirculated to all relevant staff.
5. That we will ensure that SVPP Business Support prepares and makes available on its website, a glossary and explanatory note for partner agencies setting out some of the basic terms and processes within care proceedings
6. That the review of all open cases where sexual abuse is a risk factor and the alleged perpetrator remains involved with the family/children, proposed by children's social care is finalised and tabled within the SVPP Executive.
7. That we support the response of Cafcass to this case especially in relation to the production of their management oversight guidance designed to help shape the supervision of cases and of staff. We also note and support the review of all cases of children placed at home under no or interim orders.

8. As senior leaders within SVPP, we support children's social care decision that where an interim or final care plan recommends something other than the parenting assessment recommendation or where the evidence available to be presented to the Court does not and cannot fully capture all the concerns practitioners have, then this should be escalated for more senior involvement and sign-off.

In addition, areas for improvement identified by individual agencies as part of the review process will be followed up by the Partnership Practice Review group.

Appendix 1: Agencies involved in this review

- Families and Children's Services, Wiltshire Council (this includes Support and Safeguarding and Conference and Reviewing Service)
- Wiltshire Police
- Clinical Commissioning Group BSW
- Great Western Hospital NHS Foundation Trust (Safeguarding Service and Maternity Services)
- GP surgeries for Mother, children and Adult A
- Virgin Care Limited – providers of Health Visiting and School Nursing services in Wiltshire
- Cafcass
- Nelson Trust (providing support with overcoming addiction and trauma)
- Splitz (Domestic Abuse Service)
- Young Carers
- Primary and Secondary schools attended by the children
- Turning Point IMPACT Swindon and Wiltshire Active Recovery Service (adult substance misuse service)

Contact details: SVPP@wiltshire.gov.uk