North Tyneside SAFEGUARDING CHILDREN BOARD

Serious Case Review Claire and Anne

Summary Report

Report Author: Richard Burrows

Independent Chair - North Tyneside Safeguarding Children Board and Chair of the Case Review Panel

1. Introduction

1.1 NTSCB commissioned a Serious Case Review (SCR) in relation to Claire and Anne on 23 October 2017 in accordance with Working Together 2015.

1.2 The review process brings together senior representatives from all the agencies who had been involved with the family. This ensures there is an accurate chronology of events and therefore as clear a view as possible of what agencies and their practitioners did and the extent to which multi-agency working resulted in Claire and Anne being protected and ensuring that their needs were met.

1.3 The review report concludes that these arrangements fell short over a period of time and failed to recognise and respond to the direct disclosure the children made to a number of agencies and professionals.

1.4 The review report completed by the Independent Reviewer has helped to shape and contribute to establishing learning. However the Case Review Panel and subsequently the LSCB felt that this did not ultimately provide learning that was easily accessible or that fully reflected local expectations given partners commitment to transparency, challenge and continuous learning and improvement.

1.5 As a result this summary report seeks to focus the learning and sits alongside the review report. The Case Review Panel took account of

the more recent developments resulting from the establishment of the new National Panel and in particular their guidance for a “good” report.

1.6 The overall purpose of this report is to demonstrate and set out how as a partnership we intend to respond to the learning in the report so that we can meet the expectations identified by Anne during the review.

1.7 The SCR report and this summary were subject to scrutiny by the Case Review Panel and the LSCB and were endorsed by the latter on 29 October 2019.

1.8 Initially the review was focused on the lived experience of Claire but as the review progressed her older sister Anne was also included. Anne has contributed significantly to the review and is concerned that the learning from her and her sister’s experience should be taken seriously and acted upon.

2. Brief overview of what happened, key circumstances, context and significant learning themes (for further details please see main report)

2.1 In 2017 Claire disclosed to a teacher that she had been sexually assaulted by her father. She was immediately safeguarded and a police enquiry commenced. The SCR was commenced when significant concerns emerged about the emotional harm, neglect and threats of physical abuse that Claire had experienced within the family setting. Claire had not made any previous allegations of sexual abuse but had, along with her sister, been involved with a number of agencies and joint working processes over several years.

2.2 Claire presented at an early stage and at various times with indicators that suggested neglect. This was correctly recognised and acted on by the school but did not result in consideration by Children’s Social Care that the threshold for child protection had been met. It did result in the offer of early help involvement in the form of parenting support.

2.3 This intervention continued for some time, and despite new information and events coming to light, the needs, vulnerabilities and risks each child faced were not felt to meet the threshold for a more formal multi-agency approach. The type of support offered and the way in which this was delivered meant that there was insufficient focus on the paramountcy of the children’s safety and welfare. Claire and Anne’s voices were not always fully heard by Children’s Social Care, the GP

and the wider system. Their needs, vulnerability and the harm they were suffering were not sufficiently recognised.

2.4 The school that the sisters attended were tenacious in repeatedly raising concerns based on their observations of Claire and Anne, what they were saying and their knowledge of the family. Staff found it difficult to accept the decisions by Children's Social Care not to consider the information and concerns through the child protection process. The school was in another Local Authority area and neither they, or North Tyneside, had a specific formal escalation process at this time.

2.5 When Anne was 16 years old, she was empowered, through her involvement with a local women and girl's centre, to challenge the response that she was offered by Children's Social Care. Legal advice was sought by the Centre, on Anne's behalf and as a result of the subsequent solicitors' letter, an assessment was completed, and Anne was accommodated. However, this event did not alter the approach to the family.

2.6 Following Claire's disclosure of sexual assault child protection procedures were initiated, and the subsequent plan ensured that Claire was safeguarded. In 2018 the girl's father was charged and convicted of the sexual abuse of Claire, Anne and others.

2.7 It is of note that the Review Panel sought assurance from the Local Authority that it was taking into account the emerging facts and learning from the review in terms of the ongoing protection of Claire and the longer term plan. The Local Authority conducted two internal reviews in response to the issues raised by the Panel. The Panel continued to have a level of concern that the local authority was not fully reflecting on the learning arising from the review.

2.8 Throughout the review period, all family members had regular contact with their GP practice. The GPs who saw the children and parents were therefore in a good position to form a view about the family and act in the best interests of each child. However, the GPs and the GP who had most frequent contact, were not significantly involved in or aware of the multi- agency early help intervention. This and other factors meant there was not always a focus on potential safeguarding concerns as a result of contact with the parents and Claire and Anne. The GP appears to have identified with the parents needs and wishes.

2.9 The decision to continue to provide the family with parenting support was with hindsight a poor one. This intervention, though well

intentioned, was not well matched with the unfolding circumstances and events. There were a number of reasons for this. In part it appears for the period of the review the parenting support service did not appear to be particularly integrated with other services and wider multi-agency safeguarding arrangements. This was compounded by the fact that there appears to have been a poor level of recording, supervision and review. The potential for such circumstances to arise with regard to present arrangements need to be considered by Safeguarding Partners and agencies.

2.10 The decision may have also been unduly influenced by perceptions that because the children attended a private school and the family appeared to be middle class that focusing on supporting the parents was proportionate initially. However as noted subsequent information sharing and events did not result in any successful efforts to re-focus intervention or consider intervention on the basis of child protection procedures.

2.11 Although schools followed procedures, the learning from the Review identifies that the multi-agency arrangements and therefore the agencies involved collectively failed Claire and Anne and as a result each child suffered different forms of abuse and harm. There was a failure at a statutory and pre statutory level to build an understanding of the children's needs, how the family functioned and to be able to place the presenting symptoms and events into a multi-agency process that focused on the potential risks that each child faced. The operation of thresholds to meet levels of needs, and ensure safeguarding concerns identified, were not effective. Whilst an early help response may initially have been justified, the basis for this does not appear to have been grounded in any kind of assessment.

2.12 A number of agencies, for example the GP, CAMHS, had an accumulation of evidence and Children's Social Care response did not recognise the importance of accumulative evidence when concerns were referred, and new events and information came to light. The apparent reluctance to commit to a single assessment process meant in effect that it was not until mid-way through the review period, that all concerned were able to benefit from structured and informed assessment. Even when this was the case the assessment appears to have lacked sufficient content to support effective analysis. As a result, it did not significantly raise challenges and alternatives, which in the light of what was known, meant that the thinking about the girls and the family remained "fixed".

2.13 The application of frameworks that help identify and understand neglect, emotional harm and domestic abuse would have led to more questions being asked and the testing out of potential hypotheses. Instead it appears that the collective effort accepted and to some extent maintained a view that working to support the parents would make things better for the children.

2.14 For many years the underlying principles for understanding families, parental conflict and the potential impact these can have on the wellbeing and safety of children have been embedded in policy, practice and procedure. It is therefore important that the learning identified by this review has a measurable impact on current and future practice at all levels.

2.15 There appears to be an over reliance on two occasions on the sharing of personal opinion by practitioners. These in effect sided with the views of the parents and were influential in maintaining the status quo, i.e. that the children's needs and safety could best be met with this level of support and type of approach, and perhaps inhibiting alternative views being formed and approaches being adopted. Specifically, both the Parenting Support worker and one of the GPs, compromised the safety of the children. The ways in which Children's Social Care interpreted and applied "thresholds" did not act as a potential 'check and balance" to the influence individual views had. The quality of social work assessment also means that there was insufficient challenge and a limited understanding of the information that was available.

2.16 The purpose of assessment, planning and review arrangements is to ensure that the available information and the work of different agencies results in a coherent and clear view of the family as a whole and the needs, vulnerabilities and risk that the children face. At all stages the evidence suggests that there were opportunities for this to have considered the available information and demonstrate how the available frameworks for recognising abuse, harm and exploitation may have helped to alter the overall approach.

2.17 Whilst there can be justification for any overall approach, there are a number of factors that suggest that opportunities were missed. For example, significant learning from the Review is the importance of listening to what children and young people tell us and keeping their views central to our work. Both girls were clear and consistent in describing their lived experience within the family home. Claire spoke about being frightened of her fathers' anger, had violent nightmares about father killing her and had thoughts of killing herself with a knife.

Anne spoke of her unhappiness, her low mood and suicidal thoughts which she linked to what was happening at home over a prolonged timescale. In different ways, both Claire and Anne consistently shared their concerns and fears with a number of agencies and practitioners. It is important to note that the schools were able to recognise this, but ultimately were reliant on the judgments of others despite their efforts to bring these concerns to light. The “voice of each child” was not given sufficient priority, in part because the view remained that supporting the parents was the priority.

2.18 There is documented evidence that both children made direct disclosures as to the emotional abuse and neglect they were experiencing on number of occasions to a range of professionals at different points during the review period.

2.19 This learning indicates there was not always an effective response to what children tell others, directly and through their behaviours, about their wellbeing and safety. The learning also indicates that although within the school settings their voice was heard, the way in which multi agency arrangements are intended to operate did not result in a timely or a proportionate response in terms of safeguarding. This raises an issue that if this case is representative, that agencies and multi-agency arrangements were, or are not sufficiently focused on listening to and recognising the potential importance of what children tell us, directly and through their presentation.

2.20 It may also suggest that the arrangements and pathways for responding to, recognising and prioritising concerns and shared information would have been more effective if the Children’s Social Care response was more focused on the child protection threshold and fuller assessment of needs and risks focused on the children. The action partners take in respect of this will need to reflect their understanding of what can prevent practitioners and systems from achieving a “child led and focused approach” especially given the significant investment partners have made in recent years.

3 The findings

3.1 It is clear from the evidence that Claire and Anne were not effectively safeguarded and their views about their own lives and experiences were not always listened to or acted on by some agencies. The work of safeguarding is complex, and inevitably this means that there is never one influential factor on practice, but a number of interacting factors.

This was the case here. These different factors are the six Findings of the SCR outlined below and discussed in detail in the SCR Report.

3.2

	Finding
1.	**Listening to the voice of the child and dealing effectively with children and young people's disclosures of abuse and harm**
2.	**The importance of identifying and addressing the Emotional Abuse of children and young people**
3.	**Fixed professional thinking in this case influenced the analysis of the needs and circumstances of Claire and Anne**
4.	**Domestic abuse not addressed as a concern**
5.	**The importance of addressing the neglect of children and adolescents**
6.	**Multi-agency working**

3.3 The Board and safeguarding partners are therefore resolved to act on the learning identified to include the following,

3.4 The new Multi-Agency Safeguarding Arrangements that came into operation from the 29th September 2019 will set as a priority a review of the Threshold and Levels of Need guidance. There are two reasons for this, firstly as the learning from the review indicates in this instance the guidance did not create opportunities to hear and see what the children were telling people alongside the information that was already available. Secondly, although arrangements for early help and the ways in which information, contacts and referrals has changed, we need to be sure that there is sufficient capacity and depth of understanding to ensure that risk, need and vulnerability is responded to in an appropriate and proportionate way, and that we do not become "fixed" in our thinking and therefore the way we respond.

3.5 We rely on practitioners and organisations at all levels across North Tyneside to be able to recognise and raise any concerns they have about children they are in contact with. Our thresholds, guidance, multi agency training and other measures all seek to inform and support when and how they should do this and what they might expect and may be expected from them. This means that a non statutory response such as early help is often one of the ways in which risk, need and vulnerability can be explored and managed. However we do need to be sure that those who take part in this kind of response have the necessary resources including knowledge and skills. Also, that this level of approach is informed by assessment that takes into account

the frameworks that can help recognise the reality of the child's lived experience. We therefore need to be sure that the standards of assessment, supervision and case management are robust and consistent at all levels of intervention and across all settings. This should promote and allow for the forming of a better understanding of children's situations, that take into account and reference what we know about neglect, domestic abuse, emotional and sexual harm as well as how we understand families and their dynamics.

3.6 We have recognised for some time that the quality of our early help and statutory assessments can always be improved, and there continues to be a range of measures in place to achieve this. We also know that the pressures and complexity of demands placed on systems as a whole and therefore the practitioners and managers we rely on to ensure these work effectively, can serve to counter best efforts on occasions. As a result of this review we will take a fresh look at how we can be assured that people have the necessary skills, knowledge, support and space to be able to strengthen how they work together, and which addresses the key factors identified in 3.5

3.7 We also need to be sure that we do not allow situations that result in children experiencing avoidable harm and abuse. We also need to be sure that when there are conflicting judgments and opinions that there are arrangements for and a robust culture to ensure that individuals and agencies are able to recognise and raise concerns that the best interests of children are not being addressed. This needs to include the recognition that there can be times when individuals, who may or may not represent the view of their agency, may be acting contrary to their professional standards and codes of conduct.

3.8 This suggests that there needs to be a focus on shared and single agency/professional codes of conduct and how these compliment established multi agency policies and procedures. We know that working with families where there are concerns for the safety and or wellbeing of children, is not a binary process i.e. a question of accepting for example the views of a parent instead of those of a child, but we need to be sure that there is sufficient challenge built into how we deal with each other and specific challenge when it may appear a line is being crossed. We will therefore explore ways in which we can inform and support practitioners to always act in the best interests of children.

3.9 Although we felt confident that our respective practice and approach to being child centred and that collectively we heard and acted on what children told us was reliable and embedded, we accept that there is

more we can and should do. Some of the system wide measures that are already in place such as Signs of Safety are enabling us to further develop this especially in order to focus on protection and the need to take appropriate steps. We can draw on our experiences of how we do this with children who are Looked After, as well as remembering that these arrangements need to draw on and contribute to protective measures for other children who may remain in the family.

3.10 It is clear that we will also need to identify specific measures and approaches, to further support and increase confidence in the value of challenge and escalation when one party feels that their view is not being heard or is inappropriate. We will therefore review and revise our current approach to “escalation” and what we term “professional” conversations to ensure that these reflect the learning from this review and are better embedded as a constituent part of joint working arrangements.

3.11 We have commissioned from our Case Review Group a detailed action plan which will identify achievable and measurable actions to act on the learning and improvements we have identified above. These will be subject to regular review and scrutiny by the Partnership and will form a part of the annual independent scrutiny report.