Knowsley Safeguarding Children Board

Serious Case Review

JANE

July 2018

This report is published in line with statutory guidance. In order to preserve the anonymity for the children in this family, the LSCB has:

- represented the children by names from children's literature which do not necessarily reflect their gender;
- represented people other than the children by use of initials;
- avoided the use of exact dates; and,
- removed details about local services which could lead to the recognition of the children and family

1. Background to review

1.1 In May 2017, Jane made disclosures to family members of possible sexual abuse by a relative. At that point, Jane was 4 years old. Jane's mother (MJ) reported her concerns to Children's Social Care (CSC). A multi-agency strategy meeting took place the following day. It was agreed that child protection enquiries could proceed without the need for Jane to have a specialist child protection medical. Shortly afterwards, MJ took Jane to the GP. MJ told the GP that Jane had made an allegation of sexual abuse.

1.2 The GP was concerned that Jane's presentation could be suggestive of sexual abuse. The GP submitted a safeguarding referral to Knowsley's Multi-agency Safeguarding Hub (MASH). The GP was told that there had been a decision not to arrange a specialist medical for Jane. Having taken advice from the Designated Doctor for safeguarding children, the GP asked that that decision be reviewed. The GP then understood that a specialist examination would be undertaken, although this was not the case.

1.3 In September 2017, Jane alleged an incident of sexual touching by another child in the same school year group. The matter was referred to MASH. Jane was again taken to the GP by MJ. The GP practice made a second referral to MASH. At that point, the practice became aware that there had been no specialist child protection medical following the earlier referral. The GP again consulted the Designated Doctor who recommended that an examination be arranged.

1.4 In October 2017, the Named GP for safeguarding children made a referral to the Serious Incident Review Group (SIRG) of Knowsley Safeguarding Children Board (KSCB). The Named GP was concerned that decision, in May 2017, not to arrange a child protection medical for Jane had been made contrary to advice given by medical professionals.

1.5 The purpose of the SIRG is to recommend whether KSCB should undertake a serious case review (SCR), in accordance with Regulation 5 of the Local Safeguarding Children Board Regulations 2006. The SIRG formed the view that the case did not meet the criteria for SCR as set out in Working Together 2015[1]. The SIRG acknowledged, however, that there

[1] HM Government (2015) *Working Together to Safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children*

could be learning from the case and recommended that a reflective learning review be conducted. The SIRG drew up specific lines of enquiry.

1.6 The SIRG's recommendations were accepted by the KSCB Chair, who informed the National Panel of Experts on Serious Case Reviews. At the beginning of November 2017, KSCB undertook a multi-agency reflective learning review as had been proposed. This reflective review produced a number of learning points and associated recommendations.

1.7 In mid-November 2017, the National Panel of Experts considered the information it had received from KSCB. The National Panel advised KSCB Chair that, in its view, the criteria for a SCR were met. As a result, the KSCB Chair fully reviewed all the paper work which had been produced.

1.8 The Chair considered that the reflective learning review which had been undertaken had made some clear recommendations which she was confident would lead to future improvements. However, she concluded that there was further work which may identify additional learning. KSCB Chair, therefore, indicated her intention to commission an independent reviewer to undertake a proportionate review which would include and build on the work already undertaken.

1.9 In December 2017, KSCB commissioned a suitably qualified and experienced reviewer, Isobel Colquhoun, to undertake the SCR.

1.10 A SCR Panel was established to steer the review process. The Panel comprised senior managers representing the agencies and organisations involved in the case and professionals able to provide expertise and specialist knowledge. Members of the SCR panel were:

a) Assistant Executive Director, Children's Social Care, Knowsley Council
b) Senior Conference and Reviewing Officer, Safeguarding and Quality Assurance Unit, Children's Social Care, Knowsley Council
c) Assistant Executive Director, Early Help Services, Knowsley Council;

d) Designated Nurse for Safeguarding/ Knowsley Clinical Commissioning Group; and,

e) KSCB Board Manager

1.11 The SCR Panel was chaired by Detective Chief Inspector, Merseyside Police. The Named GP and Designated Doctor were unable to participate as members of the SCR Panel as they had been involved directly in the case. The Board's Executive Support Assistant supported the SCR Panel and facilitated the review process. The SCR Panel had access to legal advice.

1.12 SCR Panel meetings took place in February 2018; March 2018; April 2018; and, June 2018. The independent reviewer attended each SCR Panel meeting and prepared relevant documents for them.

1.13 The SCR Panel agreed that the SCR would address:

a) Were allegations of sexual abuse effectively managed in relation to both:
   i. the actual or potential harm experienced by the child and
   ii. the risk posed by the alleged perpetrator(s)?

b) Is the management of risk reflected consistently in other multi-agency child protection plans for children in Knowsley who may have been subject to sexual abuse?

1.14 As KSCB had already undertaken a learning event with key practitioners and had generated recommended actions, the SCR Panel determined that the methodology for the review would be:

a) a paper review of the case, incorporating the learning from the reflective review; and,

b) a multi-agency audit of child protection referrals; ending at different stages in the case management process.

1.15 It was agreed that the review period would be from January 2016 to November 2017, covering the period when the children first had child protection plans and ending when they were made subjects of child protection plans for the second time. A combined chronology was commissioned as a basis for the case review. The independent reviewer

also met with the allocated social worker and team manager in CSC and with police officers from MASH.

1.16 In preparation for the multi-agency audit, the independent reviewer devised a specific tool which was approved by the SCR Panel. CSC randomly selected cases for audit against agreed criteria. Audit forms were completed by agencies, overseen by relevant SIRG members. When the audit forms were amalgamated, the SCR panel and the independent reviewer spent a working day considering the contents of the audits. The LSCB has been provided with the full audit report, including brief summaries of the cases reviewed. The identities all children were disguised. The findings from this process have informed the learning for the SCR review.

1.17 Jane's parents were invited to contribute to the review. Jane's father met with the independent reviewer and with the KSCB Board Manager. His views are included in the report. Jane's mother did not take part in the review.

2. Brief case history

2.1 The case history which follows is based on the combined chronology; the multi-agency learning review; notes of strategy meetings and child protection conferences; parenting assessments; discussion with the police officers in MASH; and discussion with the allocated social worker and team manager.

a) Summary of significant pre-review history

2.2 Jane was born in 2013; the fifth child of mother, MJ, and the second child of father, FJ. Jane's oldest three siblings lived with their father. Jane's nearest sibling (Michael) lived with MJ and FJ. MJ and FJ were living out of borough when Jane was born. At that point, Michael was 11 months old.

2.3 Ten years earlier, MJ's three eldest children had been living with her. In 2003, MJ reported that two of the children had been sexually assaulted while at their paternal grandmother's home. The children later alleged that they had been also been sexually abused by their maternal grandmother's then partner. As a consequence, the partners of both maternal and paternal grandmothers were considered to pose a risk to the children. It was agreed that contact between these individuals and the children would end.

2.4 Between 2007 and 2009; MJ's three oldest children were subjects of child protection plans under the category of neglect.

2.5 In 2008, the children moved to live with their father who was granted Residence Orders. It was anticipated that they would have regular contact with MJ at weekends 'as there had been a change in her lifestyle'. Very limited evidence has been provided of contact, however, during the review period.

2.6 In March 2015, MJ, FJ and their children moved to live in Knowsley. At that time, Jane was almost 2 years old and Michael was almost 3.

2.7 In August 2015**,** CSC completed assessments of Jane and Michael's needs, following a police callout to a verbal argument between parents and concerns expressed by paternal grandmother about MJ's 'substance and alcohol use'. Following the argument, MJ and FJ

separated. FJ went to live with his parents. The children were made subjects of multi-agency support plans.

2.8 By October 2015, the children were living most of the time with their father and his parents, but were having staying contact with MJ when she felt able to care for them. Paternal grandparents continued to express concerns about MJ's mental health and substance misuse.

2.9 In December 2015, a multi-agency strategy meeting took place as the result of information obtained about MJ's new partner who had a history of offences connected to domestic abuse. It was also noted that MJ's mental and physical health had been declining and it was suspected that she had ben abusing alcohol. The strategy meeting agreed that child protection enquiries would not be required. The rationale is not clear but it is highlighted in the record that the children were not living with MJ. Later that same day, however, the children returned to their mother's care, with agreed contact arrangements with FJ and paternal grandparents. It is not clear how long MJ's relationship with this partner lasted.

b) Summary of significant events during the review period

2.10 In January 2016, the first strategy meeting during the review took place in respect of Jane and Michael. On this occasion, child protection enquiries were agreed as the result of concerns about MJ's mental health; possible drug and alcohol misuse; her recent assault of a friend; and, 'unknown adults frequenting the property'. FJ was said to be unable to negotiate appropriate care arrangements with MJ.

2.11 In February 2016, Jane and Michael were made the subjects of child protection plans, under the category of emotional harm. The children were living with their father and paternal grandparents and were having 'inconsistent contact' with their mother. The local authority advised that 'the children should not stay overnight with their mother'.

2.12 At the first child protection conference review meeting, it was recorded that a Family Group Conference had taken place and that a support plan was now in place. Parenting assessments had been completed by CSC but had not been shared with core group members. The parenting assessments have, however, been provided for the review. It is

clear that those assessments have the children's circumstances and needs at their heart and considerable thought has been given to the capacity of both parents to meet those needs. In terms of risks to the children, however, the report concentrates mainly on the implications for the children's stability posed by MJ's variable mental health. It does not, for example, take into account MJ's previous history as a parent; despite the insight that might have provided into her capacity to bring about positive and enduring change for her two youngest children.

2.13 The child protection conference notes indicate that MJ was planning to move to accommodation closer to maternal grandmother and to take the children with her. A proposed risk assessment of maternal grandmother was outstanding.

2.14 In June 2016, MJ attended hospital with an injury. It was suspected that she was intoxicated when the accident occurred, although she denied this. She dropped out of contact arrangements with the children.

2.15 At a core group in August 2016, the social worker said that FJ had been advised to make an application for a Child Arrangements Order and that this application would be financially supported by the local authority. The following month, however, MJ secured accommodation near to maternal grandmother and reiterated her intention to take the children with her. FJ decided, at that point, that he would not apply to the court, as he 'wanted to give MJ the benefit of the doubt'. Instead, the couple agreed that the children would now live with their mother during the week and would stay with their father and paternal grandparents at the weekend.

2.16 The records indicate that maternal grandmother's living nearby was considered to be a protective factor, although the proposed risk assessment was still outstanding. At this point, maternal grandmother had the care of two grandchildren who had been removed from their mother's care by a neighbouring local authority. Information subsequently obtained from that authority indicates that agencies had a long history of involvement with the children, due to their mother's compromised parenting and evidence of neglect of the children's needs. An older child was accommodated with foster carers. The two younger children's living arrangements with their grandmother were secured by Child Arrangement Orders. The neighbouring local authority continued to have casework responsibility for all three children until 2015. By 2016, however, only the middle child

remained a child in need. This child was reported to have Attention Deficit and Hyperactivity Disorder (ADHD) and to have respite care arrangements alternate weekends.

2.17 The second child protection review took place a month after the Jane and Michael moved to their new home with their mother. Although the children's circumstances had recently changed significantly and a number of proposed actions had not been completed, including an assessment to determine whether MJ had learning difficulties; a majority of agencies supported child protection plans coming to an end. The conference record notes that the health visitor expressed the view that the child protection plan should continue, but she 'did not object to the case stepping down'. 'Child in Need' plans were established.

2.18 In November 2016, paternal grandparents told CSC that Michael had said that a relative of his had been 'getting his winky out' and telling Michael to 'get his winky out' too. Michael had said that this had happened at maternal grandmother's home. This relative was also reported to have said that Jane did not have a winky but that she could 'pull on it'. The relative was 18 years old.

2.19 The second strategy meeting during the review period was held. Immediately before the meeting, Merseyside police had established that the relative had moved into maternal grandmother's home. It had also emerged that maternal grandmother's former partner (who had been considered a risk to children) was also an occasional visitor to the family home. Maternal grandmother had told her grandchildren's social worker, however, that 'she didn't have the kids in the house when (this person) visited because of the allegations made about him and in order to protect him'.

2.20 The strategy meeting discussed the information provided by paternal grandparents. It was noted that the social worker had 'gone out to speak to Michael about the incident' but that Michael had not said anything more than he had already said about alleged sexually inappropriate behaviours. Michael was, however, reported to have said that his relative 'often lied and hurt him every day'. It is also recorded that one of the cousins living next door had been 'strangling Jane'. The child protection histories relating to the cousins and the older relative were recorded briefly on the notes of the meeting. Issues raised by professional actions at this point are discussed in Section 3.

2.21 The strategy meeting concluded that no child protection enquiries were required as 'no immediate child protection issues were raised' and 'no immediate safeguarding actions' were required. Assessments were to continue and the allegations were to be explored by the social worker. It was noted in the strategy meeting document that 'MJ would agree to her children not having contact with (the relative)'. Referrals were made to CSC in respect of Jane's cousins.

2.22 The Child in Need plans continued. MJ and maternal grandmother were informed of the allegations: MJ agreed that the children would not have unsupervised contact with the relative. The relative was also made aware of this agreement. It has been reported that the Child in Need plan addressed the concerns, although this is not clear from the information which has been provided to the review.

2.23 In December 2016, Jane told the health visitor that her cousin and her relative 'had been naughty' and had 'pushed Nanny and (her aunt) on the stairs'. MJ confirmed that there had been an incident. Jane had been in maternal grandmother's home but had been brought home and 'the police were contacted'. CSC was made aware of the incident.

2.24 In January 2017, the neighbouring authority recorded that Jane's relative had moved out of maternal grandmother's home. Their involvement with the family ended.

2.25 In February 2017, MJ was reported to be depressed. She was to attend a parenting course in May. No concerns were recorded about Jane or about MJ's care of children. The health chronology notes, 'allegations of sexual nature in December 2016 – these have been investigated by CSC and no further disclosures had been made'.

2.26 In March 2017, the Child in Need plans ended. The lead practitioner role passed to the school and the case was closed to CSC. It is not recorded whether MJ attended the parenting course as anticipated.

2.27 In May 2017, MJ contacted CSC reporting comments that Jane's was said to have made to FJ and paternal grandparents while at their home for weekend. MJ suggested that Jane may have been sexually assaulted by the same relative. The Manager of the MASH undertook initial enquiries: she made contact with MJ and paternal grandparents. As the relative appeared to be living again next door to Jane, advice was provided to mitigate potential safeguarding risks.

2.28 The third strategy meeting during the review period was held in May 2017. That strategy meeting was well attended by professionals from relevant agencies. The meeting identified the relevant protective factors and risk factors: as a consequence, child protection enquiries were to be carried out and a police investigation initiated. After consideration, it was agreed that no child protection medical was to be arranged and no plans were made for 'Achieving Best Evidence' (ABE) interview. The strategy meeting record does not provide the rationale for either decision. In later discussion with the independent reviewer as part of the case review, however; police officers involved suggested that Jane's just having turned four was likely to have influenced their recommendation.

2.29 Following the strategy meeting, a duty social worker visited Jane at home. It is not clear why the home visit was not by both a social worker and a police officer. Jane repeated the allegation that she had made earlier. The next day, MJ took Jane to the GP as Jane had been 'itching' and had abdominal pain. This was the GP's first contact with Jane, as the family had only recently registered with the practice. MJ told the GP that Jane had made an allegation of 'sexual abuse' against a family member. The GP noted a rash which she initially diagnosed as thrush.

2.30 Although the visit did not form part of the child protection enquiries which had been initiated, the GP became concerned that it would be outside her area of expertise to provide a view as to whether Jane had been sexually abused. The GP, therefore, contacted MASH and, at her request, it was agreed that discussion would take place as to whether the decision not to seek a specialist examination should be reversed. The GP took further advice from the Designated Doctor who recommended a specialist child protection medical examination as 'the symptoms described were not common for a child out of nappies' and as, in light of her age, Jane 'might not be able to give a satisfactory account what had happened'. This advice was also conveyed to MASH. The GP understood from discussions with MASH that a follow-up strategy meeting might be held.

2.31 The reflective learning review confirmed that, following the GP's intervention: discussion took place between professionals; there were consultations with managers by practitioners from different disciplines; and, 'some informal inter-agency discussion

between managers'. The review report suggests that some practitioners were not convinced that any benefit would be derived from a child protection examination; rather, it has been reported that they tended to the view that an examination could be intrusive and potentially harmful for the child. At the same time, one of the police officers expressed concerns about 'ignoring the advice of the specialist doctor'. There was no direct discussion with the Designated Doctor about her recommendation.

2.32 CSC record indicates that the final decision was made by CSC Head of Service. She endorsed the decisions that a medical examination was not required 'as Jane had been seen by the GP to have thrush' and that there was no need for a second strategy meeting as there was 'no new information or disclosure'. The Head of Service was not aware, at the time, however, of the advice that had been given by the Designated Doctor. This decision was accepted by practitioners of all disciplines without further challenge.

2.33 The outcome of the child protection enquiries was that the concerns were substantiated but Jane was judged not to be at continuing risk of significant harm. There was, therefore, no need to hold a Child Protection Conference. The assessment continued and a new Child in Need plan was established. 'Keep safe' work was to be completed with Jane by CSC.

2.34 It was identified that the children's relative was working in a capacity which brought him into regular contact with children. This led to an allegations management meeting taking place in June 2017: safeguarding arrangements were put in place by the young person's employer, pending the conclusion of enquiries.

2.35 The suspect was interviewed under caution. He stated that he had 'no idea' what the allegation was about and indicated that 'nothing that had happened between him and Jane which could have given rise to the allegation which she had made'.

2.36 The investigating police officer decided that Jane should be interviewed. Process and practical constraints, however, meant that the interview did not take place until a month after the original allegation had been reported. In interview, Jane repeated her allegation, but the combined chronology indicates that, in the meantime, family members had been discussing the alleged incident with her. In particular, they appear to have been encouraging Jane to express/ expand on her thoughts and feelings about the

young person who was the suspect. Jane was, as agreed, being prevented from visiting maternal grandmother's home and from having contact with him.

2.37 Over the next few weeks, it appears that MJ's mood was variable and she reported that she was finding Michael's behaviours difficult to manage. She had not been complying with her mental health medication. The children began to spend more time with paternal grandparents and seem to have spent most of the school summer holidays with them. MJ's relationship with her own mother had broken down and she was expressing a wish to move nearer her older children in a different local authority area.

2.38 In August 2017, police attended an incident of reported violence by MJ's then partner in her home. The partner had left the property before the police arrived. The incident was described as a verbal argument: no assaults were disclosed. MJ appeared to be 'under the influence of alcohol'.

2.39 In September 2017, it was determined that Michael would not be able to be interviewed by police: he did not want to talk and became upset when approached.

2.40 Also in September 2017, MJ told the social worker, in Jane's presence, that Jane had said she had been sexually assaulted in school a few days earlier. The social worker was 'taking Jane to an ABE interview' when MJ made this statement: this was now four months after the allegations had been reported. MJ repeated the description of events she said that Jane had given. Jane nodded in confirmation as her mother spoke. Jane named the child she said was responsible. The social worker informed the investigating officer (for the existing case) and the school.

2.41 The following day, the social worker met again with Jane in school. Jane repeated the complaint she had made about the named child and added that the same child had 'come into her bedroom while she was asleep' and had again assaulted her, providing details of the child's alleged actions. The named child was believed to be a girl of a similar age to Jane: they were not, however, in the same class and did not participate in the same activities. There was no evidence that the child had ever visited Jane's family home. Jane also said that paternal grandfather had smacked her 'there', pointing to her vagina. Jane said that her 'privates' were itchy.

2.42 The social worker consulted her manager and the police in MASH: it was recommended that Jane should be taken to her GP as 'she might have thrush'. The next day, MJ took Jane to the GP. She provided some detail of about Jane's most recent allegations. The GP examined Jane and prescribed topical thrush cream: a urine sample was sent for analysis. The GP completed a multi-agency referral form to CSC and told the GP practice safeguarding lead about the consultation.

2.43 The following day, the GP practice safeguarding lead telephoned CSC to advise that children who allege sexual abuse should be sent for specialist examination, giving reasons why this was the case. The safeguarding lead expressed disappointment that Jane had not been taken for specialist child protection examination in May 2017. She then spoke to Knowsley's Designated Doctor who advised that a child protection examination might still be useful for a number of reasons.

2.44 The fourth strategy of the review period took place, six days after the allegation was reported by MJ. The GP practice safeguarding lead attended, along with other relevant professionals. It was noted that the police investigation relating to the allegation which Jane made in May 2017 had been passed to the Crown Prosecution Service and that a decision was awaited. The most recent allegations made by Jane were discussed. Reference was also made to allegations made by maternal grandmother about MJ and her boyfriend who were said to be 'misusing alcohol and drugs' and bringing strange men 'drug dealers' to the house. It was determined that MJ's boyfriend was 'not to have contact with children until assessment completed'.

2.45 No police investigation was required as the child against whom Jane had made allegations was only 4 years old. In addition, significant elements of Jane's account could not have happened. The social worker expressed concerns about MJ's ability to keep the children safe and questions were raised about the extent of her learning difficulties. It is notable that an assessment of MJ's learning needs was an incomplete action prior to the ending of child protection plans in October 2016.

2.46 On this occasion, Jane was taken by MJ for specialist examination. There was no evidence of injury. The results were, therefore, 'of neutral forensic significance' but the consultant noted that history was suggestive of sexual abuse.

2.47 In October 2017, an initial child protection conference was held and the children were made subjects of child protection plans. This was the point in the case history when the case was referred to KSCB for consideration as a serious case review. Those child protection plans were still in place at the end of the SCR review period.

2.48 In early 2018, at the conclusion of police enquiries, it was determined that there was insufficient evidence to proceed to charges against Jane's relative. Although Jane's relative was no longer working with children, the allegations management process continued. The outcome was that the allegations were unsubstantiated. The complaints made by the children will remain on the police file.

2.49 The children are now living with FJ under the terms of interim Child Arrangements Orders.

3. Analysis of case history

3.1 The analysis of this case history includes issues identified in the reflective learning review undertaken by the LSCB in November 2017.

3.2 It is evident from the brief case history that the children's circumstances were complex. MJ was a vulnerable person with significant difficulties of her own. She had a history of compromised parenting which had led to her three older children going to live with their father. It is likely that many of her difficulties had their origin in her own early life. The case history suggests that the extent of MJ's vulnerabilities and the impact of her difficulties were not fully appreciated in terms of her capacity to provide safe nurturing care for Jane and Michael. FJ's perceived reluctance to take decisive action was a complicating feature.

3.3 At the beginning of the review period, Jane and Michael became subjects of child protection plans. There were significant concerns about MJ's capacity to care for the children, to the extent that the local authority had agreed to provide financial assistance to FJ to secure their care by court order. Nevertheless, within a month of that decision, MJ had taken the children to live with her with FJ's agreement.

3.4 Three weeks later, the children's child protection plans ended, although not all agreed actions had been completed. In those circumstances, the decision to end the child protection plans appears to have been premature.

3.5 In November 2016, a strategy meeting was appropriately arranged following the reports of an allegation by Michael of sexual abuse by an older relative. The social worker's speaking to the child about the incident before the meeting took place, however, had the potential to be problematic in terms of evidence-gathering. It is not entirely clear, however, whether this visit had been in fact been agreed by partners informally in advance.

3.6 Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is

aware of what is happening[2]. In this case, the report of Michael's allegation appears to have given reasonable cause to suspect that he had been sexually abused and so, child protection enquiries should have been undertaken. The rationale for concluding otherwise is not clear from the record of the meeting, particularly in the context of other allegations that Michael made. It is possible that the decision was linked to the decision by the police not to initiate a police investigation.

3.7 Discussion with MASH police officers involved indicates that their view at the time was that there was insufficient evidence to progress to police investigation. They believed that further work needed to be done with the child. This was agreed by CSC, but the nature of the 'further work' was not clarified. As a result, each agency may have had different expectations of what that work would be and what it would achieve. There were also suspicions that contact or residence issues might have played a part in the report by FJ's family. These considerations are not reflected in the record of the meeting.

3.8 The decision not to undertake child protection enquiries is significant for a number of reasons. For example, if the allegations were true, there were potential effects of that decision include: the child (and other children) could remain vulnerable to abuse; parents, carers, children and young person involved could gain the impression that the allegations were not serious; and, by discussing the nature of the allegations, offending behaviours might continue either in a different form, or with more coercion. Similarly, if, following enquiries, the allegation were found to have no substance; the process of discovery could have had the potential to gain both a greater understanding of family functioning and an insight into the children's lived experience.

3.9 When, six months later, a second allegation of sexual abuse was made against the same relative, this time involving Jane; a strategy meeting was held. On this occasion, the decision was appropriately made to undertake child protection enquiries. As noted in Section 2, on learning of the sexual abuse allegations; Jane's GP requested that a specialist child protection examination take place. This led to significant levels of discussion and exchanges of opinion. Overall, however, decision-making in response to the GP's referral was confused and unsatisfactory. The reflective learning review

[2] Definition of Sexual Abuse: KSCB Child Protection Procedures

highlighted, discussions between professionals were not recorded and no formal structure, such as the KSCB escalation process, underpinned references to managers for opinion or decisions.

3.10 The question of whether the decision not to seek a child protection medical was 'proportionate and appropriate' was discussed during the reflective learning review and considered again by the SCR panel and the independent reviewer. In the end, there is no straightforward answer as the final decision-making was severely compromised by the absence of information about medical advice. Had this information been shared at the time; the outcome might have been different. In any event, the referring GP should have been informed of the decision. Direct consultation with the Designated Doctor would also have been beneficial.

3.11 Although the decision was made in the strategy meeting not to undertake ABE interviews; when the case was transferred for investigation, ABE interviews were agreed. It is acknowledged that the purpose of an ABE interview 'is not simply to get the child to repeat on camera what she has said earlier to somebody else'[3]. Given Jane's age and the potential impact of family discussion in the interim, however, the delay in arranging the first interview (although reported to be unavoidable) could have had an adverse impact on Jane's capacity for accurate recall of events. Knowsley Council and Merseyside Police 'Police and Social Care Joint Working Protocol' (undated) states that ABE interview should be held within 24 hours of the Strategy Discussion/Meeting and that 'where there is a delay in the ABE taking place the rationale for the delay should clearly be recorded on the child's record and the police recording system'. This raises questions about where and how the decision is made about the necessity for ABE interview.

3.12 No clear rationale has been given for the decision not to hold a child protection conference at this stage, despite there being a record that 'concerns were substantiated'. Although it was agreed that there would be a written agreement prohibiting contact between Jane and the older relative; a similar arrangement had been made, following the allegation in November 2016. No evidence has been provided that the decision was informed by wider considerations of family circumstances and of parents' capacity to

[3] Re W and F (Children) [2015] EWCA Civ 1300: Appeal following findings of sexual abuse made within care proceedings where there had been significant deficiencies in the investigation into the allegations. Appeal allowed

protect the children from harm. It is notable also that there was no challenge from partners to this decision by CSC. It is acknowledged that 'Keep Safe' work was undertaken with Jane. A child in need assessment was also to be undertaken in relation to Jane's cousin. The matter of written agreements is considered in Sections 6 and 7 (Lessons learned and recommendations).

3.13 Jane's relative was appropriately referred to the Local Authority Designated Officer (LADO) to ensure that safeguarding actions were taken to protect the children the young person was coming into contact with through work. This took place within 48 hours of the strategy meeting in respect of Jane. The relative was later interviewed by police under caution.

3.14 The police investigation was still open when the final strategy meeting in the review period was held. On that occasion, Jane had given a description of significant forced sexual touching by another child aged four. Although elements of the allegation could not have happened; Jane's description of the child's behaviour was concerning. The strategy meeting, which included the GP practice safeguarding lead, appropriately agreed, therefore, that Jane should be examined as part of the wider child protection enquiries. Both Jane and Michael were subsequently made subjects of child protection plans.

3.15 In terms of key lines of enquiry set by for this review, therefore, the record indicates that there were shortcomings in the effectiveness of the professional response to the management both of potential or actual sexual harm to the child and of risk posed by the alleged perpetrator. As significantly, however, it appears that some evaluations of risk were overly narrow in their focus and did not sufficiently take into account the wider context of family functioning and of the children's lived experience. The absence of clear rationales for some key decisions has contributed to this impression.

3.16 It should be acknowledged, however, that while paper reviews can validly highlight weaknesses in professional practice; they are less effective in identifying the context in which that practice took place and the factors which might have influenced decision-making at the time. In this instance, it is notable that discussions with practitioners and managers in CSC and the police revealed a level of knowledge about Jane and family and

an ability to recognise the complexity of their circumstances which the mainly paper review has not captured. They were also able to reflect on how they had worked individually and together and could identify the workplace circumstances, individual levels of professional experience, and personal assumptions and beliefs which might have influenced their thinking and actions at the time. In both agencies, workers demonstrated openness to learning and a commitment to improvement.

4. Parents' views

4.1 As noted above, only FJ agreed to contribute to the serious case review. Both Jane and Michael are now living with him and, for the moment, their paternal grandparents. At the point of writing, the question of contact with their mother remains unresolved for the children. This is as a result of MJ's non-attendance at court. FJ understands that their child protection plans will now come to an end.

4.2 FJ was, in general, satisfied with support the children have received from CSC, although he felt 'things could have moved a bit quicker'. At the same time, he acknowledged that the first time it was suggested that he could make an application to the court; it was his decision not to go ahead. At that point, he and MJ were 'on speaking terms' and he believed that, had he gone to court, the level of conflict between them would have significantly increased. He did not want to put the children in that position.

4.3 FJ was appreciative of the social worker's support and of her efforts to secure specialist help for Jane. He was frustrated no suitable resource for a pre-school child could be found. Since the children have been living with him, FJ has been satisfied with the advice that he has been given about 'what to look out for' in future and what to do if he is worried. For the moment, however, he has no immediate concern for either child. They seem happy and content and settled at school.

4.4 FJ was pleased that the children had formal multi-agency plans during the period of the review. He felt particularly positive about there being a child protection plan which seemed to bring more structured approach and increased involvement by professionals. This put his mind at ease, when the children were not with him.

4.5 In terms of the police investigation, FJ felt that he was 'in the dark'. His only point of contact was the investigating officer. Until he was told that 'the CPS said there was not a strong enough case'; he did not know what was happening.

4.6 FJ does not recall being given information about how the police investigation would be conducted or about what would happen/ did happen during the child protection medical. FJ acknowledged that this might have contributed to his gaining the impression that

Jane's interview with the police 'could have been more informal' and that Jane was 'very upset' about the child protection medical.

4.7 In summary, therefore, the lessons that FJ would most like professionals to take from his experience are:

i. There should be specialist support locally for pre-school children who have alleged sexual abuse; and,
ii. When child protection medicals or police investigations are planned where children are witnesses, both parents should be given information about what this could mean for the child or children. It is not enough only to tell the parent with whom the children live most of the time.

5. Audit

5.1 The purpose of the multi-agency audit was to test the safety and efficacy of child protection work where sexual abuse is, or is suspected to be, a feature of family life, in line with the terms of reference and plan set by the SCR Panel.

5.2 24 cases were selected randomly for audit by CSC within the following parameters:

i. Referrals relating to sexual harm
ii. Strategy discussions or meetings where sexual harm was the principal cause for concern
iii. Child protection enquiries relating to sexual harm
iv. Child protection plans where sexual harm was a feature.

5.3 Of the 24 cases selected, 2 cases were withdrawn before audit meeting. 5 further cases demonstrated no evidence of sexual harm. 17 cases were, therefore, discussed in detail by the reviewer and the SCR panel on 27 March 2018.

5.4 The data was collected for the audit by means of specifically designed tool. Although it generally fitted its purpose, the independent reviewer and the SCR panel acknowledge that the form did not always allow the information to be collected and collated in the most effective way. In addition, it is recognised that the task of completing the audit form in the time given taxing, particularly for those agencies with significant involvement with the greater number of the families. The reviewer and the SCR Panel are grateful, therefore, to agencies, organisations and individual auditors for their contributions. The role of the LSCB administrator was also crucial in coordinating the flow of audits and in producing a record of the SCR panel discussion.

a) Selected data

5.5 The data which follows provides a context for the audit findings and lessons learned. It does not represent the complete range of data collected.

5.6 Basic data

5.7 Of the 17 cases considered in detail by the independent reviewer and the SCR Panel; 8 related to children and young people who were girls and 9 who were boys. Only 1 child was not white British and did not have English as a first language. No children were recorded as having a disability, although one child and his siblings were described in the case detail as having additional learning needs. The children in the sample came from families of different sizes; from single children to families of 4 or more brothers and sisters.

5.8 Nature of concerns

5.9 Concerns about the likelihood of sexual harm to children can arise in a range of circumstances and may not be the result of a specific allegation against a named perpetrator by the child at risk. For example, in 9 of the 17 cases audited, the suspicion of sexual harm was as the result of a child's relationship with a person who was alleged to have committed, or who had been convicted of, sexual offences.

5.10 4 children were reported to have suffered sexual harm as the result of a sexual assault. In 2 of those cases, the allegations were of assault by a non-family member. In 1 case, the audited casefile was of a child whose younger sibling had alleged sexual assault by another child.

5.11 In 3 cases, the young people were alleged to have sexually harmed another child.

5.12 Outcomes of referrals

5.13 Strategy meetings followed referrals in 12 of the 17 cases considered. Child in Need assessments took place in 3 cases. In one case, work with the young person under the council's Early Help; and, in the last case, evaluation of the allegation appears to have taken place within the context of a court directed report.

5.14 Outcomes of strategy meetings

5.15 8 out of 12 strategy meetings led to child protection enquires, including 5 where police investigations ran concurrently.

5.16 Outcomes of child protection enquiries

5.17 Of the 8 cases where child protection enquiries were carried out; 6 led to Initial Child Protection Conference and 2 to continuing assessment under Child in Need processes. Where child protection conferences were held, all resulted in CP plans under the category of sexual abuse.

5.18 Police investigations

5.19 The police interviewed the alleged perpetrator/person of concern in 4 of the 5 cases where police investigations were agreed. In one case, where the alleged offender was a non-family member, the alleged perpetrator could not be identified.

5.20 Referral to for specialist child protection medical

5.21 According to the completed audits, only 1 child was referred for specialist child protection examination at the Rainbow Centre. Auditors recorded that in a further 2 cases, the specialist centre formed part of the professional decision-making process.

5.22 ABE interviews

5.23 ABE interviews are reported to have taken place in 5 cases. In one case, the alleged victim was interviewed by another police force. In Knowsley, all 4 ABE interviews are recorded as having been completed by police only. 2 children who were identified by auditors as alleged victims were not ABE interviewed. In one instance, the young person declined ABE interview in respect of assault by non-family member which had taken place some years before. In the second case, the suspect was 9 years old and it was determined not to be in the public interest to pursue a criminal investigation.

5.24 Interviews of by police of suspects/alleged offenders/ persons of concern

5.25 In 9 cases, the person who was suspected having committed an offence against a child was interviewed by the police. Of those, 6 cases were still open investigations at the time that the audit was undertaken. In 3 cases, the outcome was recorded as 'No further action'.

5.26 Additional information provided to the audit

5.27 4 school audits were completed. In all 4 cases, the school had been involved in multi-agency assessments/ plans of pupils. 15 GP audits were completed but these were not available prior to the day of the SCR panel meeting. 8 GP records contained no record of concerns about sexual harm. In 4 cases out of 5, where the child was or had been the subject of a child protection plan, the auditor was able to see information about this on the child's medical record. Details of the other case have been provided to the Safeguarding and Child Protection Unit for follow up.

5.28 Only a few of the children in this sample were/had been registered with Children's Centres and where there had been involvement this was not related to issues of sexual abuse. Similarly, there were few cases where Early Help had been involved before the referral relating to possible sexual abuse was received.

5.29 Probation Services completed 1 audit form.

b) Analysis of data

5.30 The cases which were considered by the reviewer and the SCR Panel varied in their complexity, as was intended. No child's situation was entirely straightforward, however, and in the majority of cases, there were complicating features which presented a challenge to professionals working with the children and their families.

5.31 Although there was variability in both the quality of audits and in the described professional practice; overall, the reviewer and SCR Panel found that work was generally of a good standard with some examples of excellent multi-agency working. Assessments, case planning and interventions were generally timely and appropriate. It was unanimously agreed that the best examples were cases where analysis was clear and the rationale for decision-making was clearly recorded. No cases in the sample were considered to require immediate remedial action. The Assistant Executive Director CSC asked for casework with one child to be reviewed. A number of themes emerged from the discussion.

5.32 Strategy meetings

5.33 Strategy meetings were generally found to be well attended by the correct people; they were purposeful; and, the correct thresholds were applied. In the majority of cases, child protection enquiries followed. Where decisions were made instead to undertake Child in Need assessments, these were generally considered to be appropriate, although the rationales for those outcomes were not always recorded clearly.

5.34 Child in need assessments and plans

5.35 Some concerns were expressed that child in need assessments conducted by CSC did not sufficiently involve partner agencies. In addition, although child in need assessments were the agreed decisions of a strategy meeting; it was not obvious when assessments were completed, that there had been a referral back to the actions agreed at strategy meetings to ensure that they had been completed. There was no evidence, either, that the decision not to undertake to child protection enquiries was formally reviewed on completion of the child in need assessment.

5.36 Where the decision of the strategy meeting was to undertake a child in need assessment, the audit revealed that there was also less likelihood that partners would be aware of the outcome.

5.37 The importance of taking into account multi-agency perspectives when CSC team managers decide to end social work involvement with a child in need was also emphasised in the SCR Panel audit meeting. This is already an expected standard of practice.

5.38 Written agreements in respect of contact in family situations where there is risk of sexual harm

5.39 Written agreements with individuals and families were common features of casework in this audit; the majority of these agreements related to supervision of contact between children and alleged perpetrators/ people of concern. The individual agreements were not examined but reviewer and the SCR panel had strong reservations about the viability and durability of some of these agreements in the circumstances of the case. This was

also identified as an issue in the case of Jane. In the SCR Panel discussion, it was reported that the local authority and the LSCB have independently reviewed practice in this area and that practice is considered to be developing. CSC reported that some of these agreements could be considered to be a 'legacy' in the move to increasingly robust 'safety planning'.

5.40 Risk assessments

5.41 The audit contained examples of good risk assessments. Where the alleged or potential perpetrator was a child, there is evidence of AIM assessments being completed and/or of the local authority commissioned an external expert to guide risk assessment and management. There is evidence of schools being actively involved in risk management plans. A number of young people were also referred to the Sexually Harmful Behaviours Panel.

5.42 Although there were no cases which gave rise to immediate concern, risk assessment and risk management of adults was not as well evidenced in most cases. In particular, in 2 cases where the father was suspected of accessing abusive images of children; queries arose as to how risk would be assessed if the evidential threshold for prosecution were not met, even in there were reasonable grounds to believe that the allegations were true.

5.43 In one case, the person of concern self-reported historic abuse of siblings. The resulting multi-agency response in respect of all parties concerned was considered to be excellent: both 'timely and proportionate'.

5.44 Direct work with children

5.45 Combined audits and reference to records revealed examples of good direct work with children who had suffered or were considered to be at risk of harm. There was reference to theoretical approaches and to the use of accredited tools. One child, in particular, was considered to be an example of a successful stepped approach, where decision-making was clearly evidenced. From the files, there was found to be less evidence of support to children and young people who posed an actual or potential risk of sexual harm to others. Later discussion between the independent reviewer and the Head of Service for Safeguarding and Quality Assurance about those specific young people confirmed that all

were known to the Sexually Harmful Behaviours Panel which was overseeing multi-agency casework with them.

6. Lessons learned from case review and audit

6.1 Although the limitations of a non-systemic multi-agency case review have been acknowledged; the analysis of the case history has clearly identified that there were shortcomings in the identification of potential harm to Jane, Michael and their cousins. As a consequence, the level of intervention by agencies was not always consistent with the children's need. The local authority and the LSCB, however, are aware that this was a feature a recent history of services for children and young people in Knowsley[4].

6.2 Since 2014, progress in bringing about improvement in local authority social work practice has been intensively monitored by the government inspectorate, Ofsted. In its re-inspection report of 2017, Ofsted acknowledged that that practice had significantly improved and that these changes have been through a wholesale and effective cultural and structural transformation[5]. It is not the intention of this SCR report, therefore, to identify lessons which are already known or to make recommendations which form elements of existing action plans. This proportionate review will focus on lessons learned specifically in respect of the management of sexual abuse allegations as found in the case review and through the multi-agency audit.

6.3 FJ's experience has led to two specific lessons which are also included.

6.4 Lesson 1: Where there are concerns that a child may have been sexually abused, the views of a specialist child protection medical practitioner should, be considered when deciding as to whether a child protection medical is required.

6.5 The reflective learning review made reference to Royal College of Paediatrics and Child Health document: 'Service specification for the clinical evaluation of children and young people who may have been sexually abused (2015)'. That document advises the involvement of health professionals in early multi agency discussions for all children where child sexual abuse is being considered. It also recommends that the LSCB should

[4] Knowsley Council: Inspection of services for children in need of help and protection, children looked after and care leavers (2014)

[5] Knowsley Council Re-inspection of services for children in need of help and protection, children looked after and care leavers (2017)

agree a multi-agency protocol, describing how children should be referred for a paediatric forensic assessment. This lesson links with Recommendations 1 and 2

6.6 Lesson 2: Where there are suspicions that a child has been sexually abused the strategy meeting should ensure that a process for determining the need for Achieving Best Evidence interviews should be in place and that planning for any proposed interviews is consistent with best practice.

6.7 The Ministry of Justice guidance on interviewing victims and witnesses identifies the expectations of good practice where there is an 'intersection between child protection and criminal justice systems'[6]. This document emphasises the importance of planning when ABE interviews are to be held. It states, "A well-conducted interview will only occur if appropriate planning has taken place… The success of an interview and, thus, an investigation could hinge on it".

6.8 The guidance also makes clear that, provided both the police officer and social worker have been adequately trained to interview child witnesses in accordance with the guidance, there is no reason why either should not lead the interview. The decision as to who leads the interview should depend on who is able to establish the best rapport with the child. These issues are reflected in Knowsley Council and Merseyside Police 'Police and Social Care Joint Working Protocol (undated)'.

6.9 In SCR Panel discussion, it was agreed that by the police and Children's Social Care that changes in ABE practice is necessary. Although it was generally believed that improvements were effected in the recent past; the audit findings of this SCR suggest that these changes have not endured. These lessons links to Recommendations 3.

6.10 Lesson 3: The conduct and record of child protection strategy meetings are fundamental to good safeguarding practice. In particular, there is a need to ensure clear recording of the reasons why key decisions have been made.

[6] Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures (2011)

6.11 It is acknowledged, that the multi-agency audit report found that there was evidence of good practice in respect of the conduct of strategy meetings. Recent improvements are reported to have been made in relation to the scope of multi-agency discussion; to the expectation of analysis of the information provided; and, the recording of the rationales for decisions made and actions agreed.

6.12 In particular, it has also been reported to the SCR reviewer that strategy meetings' are now recorded 'live' and each agency representative is expected to formally endorse the decisions/ recommendations that have been made. Following the reflective learning review, the form has also been adapted to allow for an option to revisit the decision within a pre-determined timescale.

6.13 Nevertheless, given the gaps which have been identified in the case review, the LSCB should be satisfied that decisions taken during strategy meetings are accurately recorded and contain sufficient information to establish the rationale for such decisions.

6.14 It is noted that a decision making model has been developed by the LSCB and cascaded to practitioners across the partnership.

6.15 This lesson is linked to Recommendation 4.

6.16 Lesson 4: <u>When strategy meetings determine that 'child in need' assessments should be undertaken; these assessments must consider whether the original safeguarding concerns have been resolved satisfactorily.</u>

6.17 Local authority partner agencies should also be involved in these assessments. Outcomes should specifically take into account whether all actions agreed at the strategy meeting have been completed. Agencies which have contributed to the assessment should be informed of the outcome. It is noted that a review of child in need process is current.

6.18 This is linked to Recommendation 5.

6.19 Lesson 5: <u>'Written agreements' to prevent or supervise contact between children and individuals who are considered to pose a risk of sexual harm to them are likely to be ineffective as 'stand-alone' safeguarding measures.</u>

6.20 Written agreements can be helpful tools in the early stages of child protection enquiries, while the evaluation of risk is current. However, as noted above; both case analysis and audit findings have demonstrated that their viability as a child protection measure is likely to be erased in the longer term, particularly where 'victim' and 'perpetrator' live as part of the same family or its active network. It is acknowledged that the local authority has recently instructed staff not to use written agreements or contracts of expectation. Safety planning tools have been introduced. This lesson is linked to Recommendation 7.

6.21 Lesson 6: Practitioners and managers need to be confident that their professional opinion in safeguarding matters will be taken into account and that, where issues arise which cannot be resolved informally, they can refer to the LSCB escalation process

6.22 There was little evidence, in either the case review or the multi-agency audit, of professional challenge by local authority partner agencies, although there were occasions when this would have been appropriate. On the particular occasion when the GP did make representations, her concerns were not addressed systematically and she was not informed of the outcome. This meant that, even if she had judged that the matter should be pursued through the LSCB escalation process, she was not in a position to do so.

6.23 This links to Recommendation 7

6.24 Lessons 7 and 8 reflect the most important issues raised by FJ

6.25 Lesson 7: The children's father felt that Jane was disadvanted by there being no identified specialist support locally for pre-school who have alleged sexual abuse.

6.26 Lesson 8: When child protection medicals or police investigations are planned where children are witnesses, both parents should be given information about what this could mean for the child or children. It is not enough only to tell the parent with whom the children live most of the time.

6.27 These lessons are linked to Recommendations 8 and 9.

7. Recommendations

Recommendation 1:

KSCB, local authority procedures and MASH procedures should be amended to include:

'When there are concerns that a child may have been sexually abused, the views of specialist child protection medical practitioners should be considered when deciding whether a child protection medical is required'.

There is already a requirement that the rationale for the final decision in respect of medical examinations should be clearly recorded within the strategy meeting document.

Recommendation 2:

KSCB should oversee the development of a multi-agency referral pathway for children who require a paediatric forensic assessment. This should be consistent with the Royal College of Paediatrics and Child Health document: 'Service specification for the clinical evaluation of children and young people who have been sexually abused (2015)'.

Recommendation 3:

KSCB should require the police, CSC and health to agree, and implement, a joint process which will ensure that when an ABE interview is required; actions which follow are consistent with the Ministry of Justice guidance; 'Achieving Best Evidence in Criminal Proceedings': Guidance on interviewing victims and witnesses, and guidance on using special measures (2011). Joint processes must ensure smooth arrangements for deciding whether an ABE interview should be arranged.

Recommendation 4:

KSCB should consider, as part of its quality assurance process, auditing the extent to which strategy meetings are being conducted and recorded in ways which:

- **make clear what influenced decision-making; and**
- **make explicit why actions have been agreed or recommended.**

Recommendation 5:

The current review of child in need processes should include the requirement that:

'When strategy meetings determine that 'child in need' assessments should be undertaken; these assessments must consider whether the original safeguarding concerns have been resolved satisfactorily'.

Recommendation 6:

KSCB should be assured that the local authority's safety plans constitute viable child protection measures in practice.

Recommendation 7:

Agencies and organisations which comprise KSCB should be required to develop a communication plan to raise practitioners' awareness of the KSCB's dispute resolution and escalation process and to take any necessary steps to increase confidence in its use.

Information about the KSCB's dispute resolution and escalation process is already given through KSCB training

Recommendation 8:

Commissioners of services for children who have been sexually abused should consider the viability of developing a specialist resource for young children whose developmental stage is immature and who are not at present eligible for specialist services.

Recommendation 9:

Policies, procedures and training relating to child protection medicals and child witnesses in police investigations should stress that, where parents are separated, both should be provided with appropriate information about what these processes entail and how the parent can support their child.