Devon Safeguarding Children Board

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Devon Safeguarding Children Board

SERIOUS CASE REVIEW
CN11 'BONNIE'
January 2016

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District Councils ■ Police ■ Health ■ Devon County Council ■ Careers South West
Youth Offending Team ■ Probation ■ CAFCASS ■ SaferCommunities
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PROPERTY OF DEVON SAFEGUARDING CHILDREN BOARD

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1. Introduction

This case was identified for Review as meeting the criteria detailed in Working Together to Safeguard Children 2015[1] (p.75 2.ii.) concerning a child who has been seriously harmed and there is cause for concern as to the way in which the local authority, their Board partners or other relevant persons have worked together to safeguard the child.

Bonnie was the subject of sexual abuse at the age of 2 years, having been previously protected by multi-agency Child Protection Plans and the subject of a Special Guardianship Order with stringent requirements for support and monitoring.

The purpose of this Review is to

- identify lessons for the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- identify required changes; and
- improve inter-agency working to better safeguard and promote the welfare of children.

1.1. Succinct Summary of the Case

Bonnie was 2 years and 4 months old when found to have suffered sexual abuse.

She had been the subject of a Child Protection Plan in early life, and later placed into the care of her maternal grandmother (MGM) following care proceedings which decided upon a Special Guardianship Order (SGO) in February 2013. The family are white British with no confirmed religion and English as their first language.

The Special Guardianship Report had detailed the previous chaotic lifestyle and neglect of Bonnie by her mother, and included identification of risk of sexual abuse from the child's maternal grandfather (MGF). Grandmother had not lived with her husband for more than 12 years, and they reportedly had no contact. The Special Guardianship Report identified a positive and co-operative working relationship between grandmother and the local authority's social worker, and that she had full understanding that the grandfather should have no contact.

A referral to Devon Children's Social Care through the Multi-Agency Safeguarding Hub in September 2014 alleged that grandmother had allowed the grandfather to move into the family home. A strategy meeting initiated a s47 assessment (Children Act 1989) which progressed to an Initial Child Protection Conference (ICPC). The grandmother was required to ensure no contact with grandfather, and for any contact to be immediately disclosed to the allocated social worker.

In late September 2014 the family's Support Worker informed the social worker of unusual soreness to the child's bottom. No medical examination took place for 5 days. On 1st October 2014 concerns were expressed by the Nursery and Children's Centre, following the child's routine nappy change, and a forensic medical examination undertaken at the Sexual Abuse Referral Centre identified her to have suffered sexual abuse, including penetration.

Bonnie was made the subject of an Emergency Protection Order (EPO) on 2nd October, and subsequently placed in care.

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

1.2. The Scope of this Serious Case Review (see also Appendix Four)

Bonnie suffered significant harm whilst the subject of significant multi-agency concern and support. This Review considers the period from 1st October 2012 to 2nd October 2014 to gain understanding of:

- the assessment and analysis of the risks identified;
- why the medical was not undertaken in a timely manner;
- how well agencies communicated with one-another;
- the effectiveness of information sharing;
- inter-agency challenge and escalation of professional differences;
- whether all practitioners understand the signs and symptoms of sexual abuse; and
- how well practitioners understand the nature of disclosure of abuse in very young children.

The review represents an appreciative inquiry into the practice and systems at the time, and considers whether the abuse could have been prevented.

1.3. The Review Process

In conducting this Review the author has considered case records and chronologies of agency involvement during the period, and held conversations with leading professionals involved with the child and family. This included a group event for the Case Group to reflect upon and identify the practice and multi-agency systems that influenced the events surrounding the abuse of Bonnie. The group conversation followed the process of systems inquiry, focussing on the child safeguarding system and allowing key issues to be explored in the context of the practical conditions at the time of the events.

Conversations were undertaken with:

Health Visitor (1), Virgin Integrated Children's Services, Devon
Family Support Worker, Children's Centre Action for Children
Service Manager, Action for Children
Social Worker 1, Devon Children's Social Care, 1st October 2012 – October 2013)
Social Worker 2, Devon Children's Social Care, September 2014 – Present)
Practice Manager, Devon Children's Social Care
Detective Sergeant, Devon & Cornwall Police
Detective Constable, Devon & Cornwall Police
Guardian, CAFCASS
Forensic Medical Examiner, Sexual Abuse Referral Centre, G4S

With additional reports considered from
General Practitioner (x2)
Health Visitor (2)

Professional practice has been considered with reference to local procedures, national policy guidance and research related to best practice. Findings are documented here and offered with recommendations to the Devon Safeguarding Children Board for decisions and appropriate action.

1.4. Family Involvement
There have been no meetings with family members. The maternal grandmother was advised of the review, in a brief telephone discussion with the Author. Two dates for a potential individual meeting were offered and declined.

1.5. Report Structure
This report has been written taking into account the requirement within Working Together to Safeguard Children 2015 that it should be a public document. A number of specific and/or personal details relating to family members and other participants have been omitted to respect privacy and ensure confidentiality. The report offers an analysis of the findings from agency responses.

2. Family History
Bonnie's family members have been the subject of serial statutory involvement with Social Care and the Police.

2.1. **Family members:** (all identified in relation to Bonnie)

Subject: Bonnie: born 2012

Mother: born 1990

Father: not verified. No father named on birth certificate.

Sister: born 2009, lives with birth father subject to Residence Order.

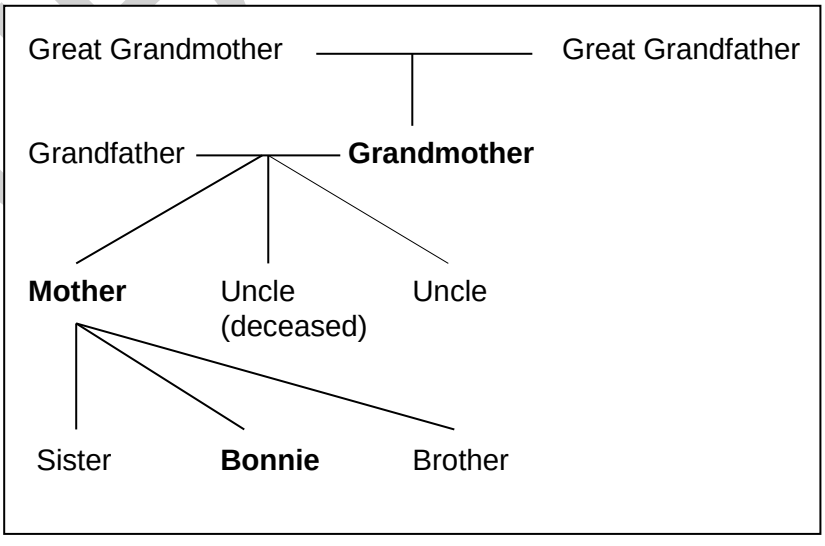
Maternal Grandmother: born 1972, married 1992, divorced 2003.

Maternal grandfather: born 1963, married 1992, divorced 2003.

Uncle born 1992.

Uncle born 1993, deceased 1996.

Nationality: White British, English as first language, no stated Faith.



2.2. **Bereavement:** Bonnie's maternal grandparent's marriage had suffered traumatic events, including one of two sons dying at three years of age in a fire in their family home. The fire was recorded in Devon County Council (DCC) files as "accidental". The surviving son later told a social worker he had

felt he had started the fire. There is significant research identifying fire-raising as a behavioural response to child abuse in the family, ranging from poor family relationships, "warring parents", to a significant degree of sexual abuse (Prins.H. 2002 p80). This element of family history is referred to in the assessment and Special Guardianship Report, 2014, relating to Bonnie.

2.3. **Domestic Abuse:** Subsequent discussions between children's social care and Bonnie's maternal grandmother stated that significant domestic abuse by her husband against her and the children only started after their son's death, which he blamed her for. She had been hospitalised by the severity of abuse by her husband on a number of occasions, resulting in a Court Order prohibiting him from living in the same town as his wife. Social Care records report Bonnie's mother's recall of seeing and being involved with her parents' domestic violence, and she left home at 16 years of age, severing contact until returning home at 19, pregnant with her first child. The mother had a chaotic and risk-taking life-style, requiring support from the Disabilities Team. This reflects a significant level of insecurity, offering insight into the level of care afforded to her during her own childhood, and raising questions as to the placement of Bonnie with her maternal grandmother.

2.4. **Suspected Sexual Abuse:** The grandfather has a series of unproven allegations of sexual abuse. Following marital separation in 1999, he requested and was granted fortnightly contact with his remaining two children. When 6-years old, the brother said that his father was hitting him and sexually abusing his sister, who in turn said at the time that "daddy tried to do rude things" but later refused to confirm this, representing a pattern of denial often associated with childhood accommodation to sexual abuse (Summit R.1983). Grandmother reported the disclosures to the Police. Following investigation there was no evidence of sexual abuse.

In 2002 Grandfather received a caution for hitting his son, and was classed as a "Schedule 1 Offender". At the same time, Police contact records assess the risk of domestic violence from the Grandfather as "low". In 2003 neighbours alleged seeing him in bed with Bonnie's mother, then aged 13, but Children's Social Care considered the risk to be low, with no further action. There were also unsubstantiated allegations of sexual grooming. It was agreed that there be no further overnight stays between children and grandfather, and noted that grandmother did not appear to see the dangers. In 2011 Police investigated an allegation that the grandfather had raped an 11-year-old girl and was charged with two offences and later acquitted of both. Bonnie's uncle chose to continue contact with his father when he was 9 or 10 years of age in public places as he was not allowed in private areas, and finally moved in with his father permanently when aged 17, and into adulthood. In offering evidence to this Review, social worker B quotes from a Strategy Meeting that Bonnie's mother had admitted having sexual intercourse with her father and had said they were not allowed in the same town.

2.5. **Learning Difficulties:** The mother's cognitive abilities fall within the borderline to extremely low range and her full IQ score was measured at 71. A psychology report for the mother, undertaken for a Special Guardianship report, indicates that cognitive ability alone only has a significant negative impact on parenting when full IQ score is below 60. She displayed avoidant

behaviour at school and maintained this avoidant behaviour as an adult, including a lack of engagement with agencies during pregnancy with Bonnie, and limited ability to recognise the needs of her children. Support as an adult came from the Devon Learning Disability team, whose role was more concerned with the practical support, especially for housing, rather than therapeutic intervention. Bonnie's mother does not accept that she is not in a position to care for her children.

Mother and grandmother have been subject to psychological reports, as outlined in the Special Guardianship Report. The relationship between the two was assessed as peppered with disagreement, with the great grandparents acting as mediators. Grandmother was identified in the reports as having some difficulty in providing narratives, synthesising information and understanding relatively complex issues. It was observed that this can result in her offering conflicting or contradictory information at times, and assessed as evidence of avoidant strategies rather than calculated dishonesty. A psychological assessment of Grandmother in 2012 recognised her as having borderline to low verbal comprehension and working memory, and reduced capacity to protect or meet the needs of Bonnie when stressed, with a lack of ability to reflect back on previous experiences and behaviours. The Report identified her as able to provide secure care for her grandchild.

3. Findings

First Period: Insecure Attachment in Early Life

3.1. **A strategy meeting held in December 2011** discussed the unborn child (Bonnie), deciding that the baby may be at significant risk of physical harm and neglect. Following birth, Bonnie was made the subject of a Child Protection Plan. The mother was known to have a chaotic lifestyle, with her first child made the subject of a Child Protection Plan and placed in the care of her natural father. In 2012, the assessment of risk to the first child found mother to have a consistent pattern of risk-taking behaviours and no indications of change or progress towards stability.

The man considered at the time to be the father of the unborn child was said to be the subject of significant child protection concerns, including indecent assault against a female under 16 years of age. The couple's relationship was the subject of a DASH (Domestic Abuse Stalking and Harassment) assessment as medium risk. By March 2012 the relationship had ended and the mother had a new partner. The multi-agency considerations did not include any information about the grandfather. Assessment at that time was not based upon the more thorough single assessment process used today.

3.2. **Bonnie was born at the end of May 2012** with mother and child discharged from hospital after 72 hours to a mother and baby home in Cornwall for a 12-week supportive placement, before going to live at the home and under the care of the maternal grandmother, the subject of a voluntary care order under section 20 of the Children Act 1989. The mother was considered not able to care adequately for Bonnie without extensive supervision. She was receiving a level of support from the Learning Disabilities Team of Devon's Adult Social Care Service, with little evidence of joined-up working between child and adults services.

There appears to have been strong social work support from Children's Social Care to the child and grandmother at this time, but reduced contact with mother after she left the household because of tense relations with grandmother. In both cases, it would appear the assessments were more focussed on the needs of the adults rather than the needs and risks associated with Bonnie. The services to the family were not directly linked, with plans for the mother developed separately from plans for the care of Bonnie.

The implications for the child's development, and particularly a recognition of on-going attachment difficulties, were identified. However, there was no assessment method for correlation of related risk indicators. Devon now utilises the RISK 1 and RISK 2 Assessment tools to ensure a much higher level of critical risk evaluation. There is also a Parent and Baby Assessment Team available now, which would probably have been utilised had they been in place at the time.

Second Period: Analysis of Risk - The Special Guardianship Assessment

3.3. **In August 2012, Bonnie was removed from the Child Protection Plan** and supported as a Child In Need (CIN). The Local Authority social worker A continued to work with the child and family and was considered to have built positive working relations with the grandmother in particular. The grandmother was agreed as the carer for Bonnie in her own home, and was fully co-operative and keen to share information with agencies. She sought advice as and whenever necessary. It was decided that the Local Authority should seek a Special Guardianship Order - a formal court order (under the Special Guardianship Regulations 2005[2]) conferring parental control of Bonnie upon the maternal grandmother. Regulation 12 specifies:

> **12.**—(1) Where the local authority carry out an assessment of a person's needs for special guardianship support services they must have regard to such of the following considerations as are relevant to the assessment—
> (a) the developmental needs of the child;
> (b) the parenting capacity of the special guardian or prospective special guardian, as the case may be;
> (c) the family and environmental factors that have shaped the life of the child;
> (d) what the life of the child might be like with the person falling within sub-paragraph (b);
> (e) any previous assessments undertaken in relation to the child or a person falling within sub-paragraph (b);
> (f) the needs of a person falling within sub-paragraph (b) and of that person's family;
> (g) where it appears to the local authority that there is a pre-existing relationship between a person falling within sub-paragraph (b) and the parent of the child, the likely impact of the Special Guardianship Order on the relationships between that person, that child and that parent.

3.4. **The Special Guardianship Report** was completed by Social Worker A in February 2013, confirming that the child's mother was assessed as unable to care for her child, and resulting in the child being the subject of a Special Guardianship Order to her maternal grandmother. Social Worker A recalls the challenge of constructing the report, where he undertook significant investigation in order to understand the various characteristics of the family and associated risks. This included an adequate number of meetings with the grandmother and other family members to gain sufficient knowledge of family dynamics and

[2] http://www.legislation.gov.uk/uksi/2005/1109/regulation/12/made

building an honest relationship with grandmother where she displayed close co-operation and engagement. An extended family genogram was constructed, and paper files dating back over 10 years considered, where available. Social Worker A undertook frequent supervisory discussions focusing upon the compilation of the Special Guardianship Order with their line manager. A colleague, later to manage the Special Guardianship Order processes in Devon, recalls the complexity of the family history and discussions between colleagues of this family's comparative risk and resilience factors:

"This was not a simple assessment, there were many complex components."

3.5. The child's independent Guardian – Child and Family Court Advisory and Support Service (CAFCASS) has confirmed their effective engagement with the grandmother and child. The Child's Independent Guardian, a qualified social worker employed by CAFCASS to undertake independent assessments in the best interests of the child, observed the due diligence shown by Social Worker A in the compilation of the report. The Guardian undertook a home visit with the Social Worker, and shared the same conclusion that there was just enough evidence to "tip the balance" in favour of grandmother taking care of Bonnie. The Guardian supported the Social Work Report's recommendations to the Court, whilst emphasising that this was a borderline case requiring painstaking consideration towards a judgement based upon the proposition that a child's welfare is best served within their own family, rather than in care.
The report identified the chaotic and traumatised history of family relationships and events, and characterised the grandmother as compliant and trustworthy. It is apparent that the CAFCASS Independent Guardian and Social Worker A, and perhaps the Court, worked to the presumption that a child's best interest is generally to be cared for within their natural family, with the assessment appearing to seek evidence supporting permanency with grandmother rather than making any comparisons with alternative options.

3.5.1. Lesson One: Predictive analysis of risk must include the history of family relationships and events to identify unresolved risks rather than submit to a rule of optimism:

In this case, the social work assessment included historical research and documented significant abuse in the family's recent history, the evidence that determined adequate parenting by grandmother was based upon very immediate and current conditions and certainly not past events.

The Special Guardianship Order recommendation included clear understanding of the level of insecure attachment already experienced by Bonnie, but separated this from the trans-generational poor attachment between grandmother and her own children, and from the historical patterns of chaotic parenting and neglect where grandmother was a central figure. The report also made reference to the grandmother's lack of capacity to appreciate the risk of harm posed to children by her husband, grandfather to Bonnie, yet appears not to have considered this as part of any predictive analysis.

The structure of Special Guardianship Reports at the time required separate sections for each family member, potentially fragmenting analysis to a point of limiting any clear overview. Whilst the child was not at an age to be able to speak for herself, evidence of early insecure attachment was offered to the court, and should have been better considered within the requirement to take the "child's own feelings" into account.

> *Social workers, their managers and other professionals should always consider the plan from the child's perspective. A desire to think the best of adults and to hope they can overcome their difficulties should not trump the need to rescue children from chaotic, neglectful and abusive homes. Social workers and managers should always reflect the latest research on the impact of neglect and abuse…*
>
> (Working Together to Safeguard Children 2015, clause 49, p 24).

3.6. The Special Guardianship Order was granted in February 2013 at the Family Proceedings Court in full knowledge of the above. The social work report stated:

> "…some serious concerns; there is a history of complex relationships between [grandmother], her children and some previous partners, where domestic violence has been present. [Grandmother] was not able to manage the complex combined needs of her three children, in conjunction with the domestic violence she experienced and without easy access to her family network. This must be considered in relation to [grandmother's] level of understanding, own attachment style to her parents, and capacity to manage complex and stressful situations."

Recommendations included a 12 month supervision order to Devon County Council, and

- Systemic family therapy to explore and address the relationships within the family, dealing with their interactional patterns and dynamics
- Family group conference to ensure a family plan and support package which acknowledges [grandmother's] needs and those of [Bonnie] is agreed
- Referral to families in grief to offer [grandmother] the opportunity to explore the death of [her son] if she feels this is suitable
- Social Work support in establishing a contact routine and structure.
- On-going support for [mother] from the Learning Disability Team.

3.7. **The granting of the Special Guardianship Order** was on the understanding that grandmother fully engaged with the support offered by the Local Authority and their subsequent plans in respect of Bonnie until she reaches the age of eighteen. The Child's Independent Guardian supported the Special Guardianship Order as being in the child's best interests, enabling her to remain within her birth family whilst be providing with good enough parenting. Grandmother had made substantial changes to her life over a long period of time and was stable and in-charge of her situation. With hindsight, the Guardian, whilst seriously concerned by the subsequent abuse, remains clear that the social work assessment, and her own, was accurate and based upon a detailed analysis of the risks and benefits of the placement to the satisfaction of the Court.

The safeguards agreed by the Court were substantial and broad in scope, requiring continued strong multi-agency support and provision. The requirement for a Family Group Conference was not offered in practice, with the service not a core provision nor mandatory at the time. Great grandparents were agreeable to offering extended support towards the care of Bonnie. Grandmother did access the Children's Centres and nursery care for Bonnie as part of the contracted Special Guardianship Order recommendations. Bonnie attended the local nursery supported by "*2gether*" funding.

Not all the safeguards were fully carried through or maintained. The recommendations for the Special Guardianship Order relied heavily upon the positive relationship between Social Worker A and grandmother, which was characterised by a strong level of mutual trust. The assessment relied upon the continuation of the current stable condition of the grandmother and her household arrangements, and represents a significant degree of optimism given the family history.

3.7.1. Lesson Two: Need for vigilance against the potential for disguised compliance:

It is most likely that the Special Guardianship Order process took place at the time of an uncharacteristic level of calm and stability within the home, with grandmother showing full compliance with the assessment and ensuring very close co-operation with children's social care. As such, the family's history was not dismissed but not given as much weight as the immediate circumstances and desire for permanency for Bonnie within her own family.

Third Period: Fragmentation of monitoring and support

3.8. **The case was closed to Children's Social Care** 6 months after the granting of the Special Guardianship Order, following a Child in Need Review (CiN) in early September 2013, identifying that parenting guidance and support would be offered through the Children's Centre and universal services. Supervision of the household environment was effectively transferred to the maternal *great grandparents* who had been registered foster carers and were seen as a strong protective factor, and expected to have no less than fortnightly contact. The Child in Need Review identified a condition of stability in the care of Bonnie, and a signed contract was drawn up with maternal grandmother, the closure of the case and withdrawal of Children's Social Care being agreed by the Health Visitor and other professionals in the team around the family. The following period would prove to be crucial to subsequent events, where the fresh contact of maternal grandfather with the family, including Bonnie, took place, and the grandmother broke the contract with the Local Authority previously agreed at the point of the granting of the SGO.

3.8.1. Lesson Three: Ongoing monitoring and support with regular review of risk and need should be assured for kinship placements where there has been a history of abuse in the family:

Importantly, the closure of this case to Children's Social Care reduced the level of monitoring of the child's care. Consequently, there is limited recorded information on the child's welfare for the following period of three-quarters of a year – one-third of the child's life - between September 2013 and July 2014. Devon County Council now includes a dedicated Special Guardianship Team including monitoring and support for families. It is unlikely that the closure of the case or end of monitoring and support for this family could happen today. A national government consultation and review of the procedures was taking place during the time-period of this Review.

3.9. **In the period following the granting of the Special Guardianship Order, the Children's Social Care service** was subject to significant restructuring during the period April – October 2013, with movement of social work staff between teams and into new geographic services areas. A strategic aim for professional "Pods" was initiated and then withdrawn. Social Worker A was subject to a change of team and role, and recalls systems pressures for the review and closure of children's cases, and the transfer of cases between colleagues. Social Worker A took the case of Bonnie with him into his new role and attempted to maintain monitoring contact with grandmother.

Social Worker A recalls significant changes to systems and management structures, with changes in senior personnel, pressure on the service to close cases, and pressure on services caused by staff sickness and new systems causing high caseloads. The mixture of types of casework

within the social work caseload created excessive pressures. For example, two or three deadlines for court reports could create excessive time-pressures that would limit the amount of time available to offer children and families with less immediate need for protection. The caseload imbalance was seen to be caused by poorly devised calculations for case-weighting.

An Ofsted inspection in this period had identified that Devon Thresholds for intervention required adjustment, and the resulting changes required a re-prioritisation of existing work within children's social care. Strategic planning of services changed repeatedly in this short period of time, resulting in confused structures. The perception offered from professionals interviewed for this Review was of significant disruption to social work systems and management in 2013, with a series of changes to structures, systems and social work case management causing anxiety and distraction to social work staff. This has been repeated by a number of professionals interviewed for this Review. The Ofsted inspection also found:

> "Assessments, including CAFs, are variable in quality with too many having insufficient emphasis upon risk, the analysis of risk and the specific protection needs of the child or young person. Whilst the views of children and young people are usually recorded in case files insufficient attention is given to their experiences the impact of the specific events in their life or their individual needs." (Ofsted 2013, Para 15, p 6)**:**

The change in personnel and systems within Devon County Council Children's Social Care coincided with the crucial period of monitoring and review following the Special Guardianship Order order made for the care and protection of Bonnie. Pressure on service provision was a key factor in the early closure of the case to Children's Social Care and the reliance upon universal services and elderly relatives for the monitoring of the child's development, and failing to meet the level of multi-agency co-ordination and supervision required by the Special Guardianship Order.

3.9.1. Lesson Four: Systems Impact Assessment is an essential core element of strategic planning for system change in safeguarding and child protection services. Horwath and Morrison (2007) identified that a drive towards more integrated children's services is happening in a climate of continuous change, and identified the need for an assessment of risk to multi-agency working ahead of initiating change**:**

> "Establish a shared analysis as to the strengths and weaknesses of the current arrangements and agreeing upon a rationale as to the reasons for change…plan a viable and realistic critical pathway for change with clear timescales, staging posts, and accountabilities. Research on failed organisational change has identified neglect of the people issues as a principle cause of failure." (2007, p66).

3.10. An incident on 19th June 2013 where Bonnie fell into a canal from her pushchair when 12 months old highlights early evidence of multi-

agency systemic failure to monitor the family or meet core safeguarding procedures. On the canal path alongside the site of a Children's Centre, Bonnie was not appropriately strapped into her buggy while stationary on a sloped incline towards the water.

Grandmother had failed to put the brakes on the buggy, which rolled away when she turned to unlock a gate, and she had jumped in to the canal to save the child. Grandmother and child returned to the Children's Centre, wet and in shock, and was reluctant to take Bonnie to hospital, but was finally instructed to do so by Centre manager. Grandmother evaded open explanation of what had happened, showing only concern for marks from stinging nettles on the child's leg, until nursing staff repeatedly questioned why the child was wet. She subsequently failed to wait at A&E to have her grandchild medically examined. The child was seen to be physically unharmed and discharged back into her care. Whilst an accident form was completed at the Children's Centre the next day, questions of the sufficiency of parental care, where the baby was not strapped in to the buggy or monitored sufficiently to avoid falling into water, were not pursued. There is no recorded detail of any actions by safeguarding authorities connected with this incident, despite it representing a direct threat to the child's life.

The failure of the hospital staff to raise safeguarding concerns, and the apparent failure of Children's Social Care to act on the information once known, also reflects a lack of joined-up working or consideration of the family's history of multi-agency involvement. The recollection of practitioners who later discussed the incident with grandmother was of her down-playing of the threat to life, including attempts to distract staff from the incident and a lack of emotional intelligence towards the impact upon the child. The incident offered evidence that grandmother became confused and disoriented when dealing with non-routine events. Such evidence, if shared within safeguarding procedures through a strategy discussion, would have raised the level of concern and could have prevented the case closure 3-months later. There is no record of social work involvement with the household of Bonnie and grandmother between 2nd July and 6th September 2013 when the case was agreed for closure.

3.10.1. Lesson Five: Effective and timely Information Sharing is enhanced where there is a lead professional as contact point and co-ordinator. The absence of a lead multi-agency worker for this family, either through a Common Assessment Framework process or at the statutory level of Child in Need, was a significant barrier to effective information sharing and multi-agency risk assessment at this point. Where information was shared between agencies, there was no one designated person to co-ordinate a response.

3.11. In July 2013 Police records identify that the mother of Bonnie was pregnant and made the subject of a Police Child Protection record in respect of an unborn child, to be removed at birth in October 2013 and placed for adoption. Mother was living in a tent and the subject of a

series of domestic abuse assaults from her boyfriend. In December 2013, Police records identify that mother moved into the household of grandmother and Bonnie, and that the boyfriend was also living there or visiting. This was contrary to the Special Guardianship Order requirements and signed contract with Children's Social Care, and should have raised fresh concerns for immediate action by the local authority. The couple were referred twice into the MARAC process within a twelve month period. The first referral was made by the Probation Service in July 2013. The second referral was made in April 2014 following a further incident between the mother and her boyfriend. Although this was assessed as medium risk it was referred in due to it being a repeat incident within a 12 month period.

It would appear here that the case management of the mother of Bonnie was entirely separate and disconnected from any consideration or concerns for her child and the family relationships that should have linked risk assessment and planning. Mother had been granted fortnightly contact with Bonnie as part of the Special Guardianship Order, and was sporadically in touch with the family home.

3.11.1. Lesson Six: Effective multi-agency working requires flexible and accessible structures that ensure mutual exchange of information, support and planning. The consideration by Domestic Abuse Services of children linked with their active service users should be routine and core business, as should a concern for the welfare of adult relatives be for those practitioners working with children. Any lack of co-operation between service departments should be challenged and prevented.

3.12. The involvement of Health Visitors and General Practitioners was also fragmented, with changes in Health personnel during Bonnie's first year resulting in key information not being passed-on, including the absence of transfer of case notes between areas when the family moved home between two towns. The Health Visitor A for Bonnie in 2014 records that grandmother did bring Bonnie to clinic appointments. Grandmother had brought Bonnie to a clinic on 12th June having moved recently to the area, and was recorded as having no involvement with children's services or others at that time. On 21st July 2014 a home visit was undertaken without access to any family health records, with the purpose of assessment for the *Healthy Start* programme for vitamin supplements and dietary support for the child.

The Health Visitor recalls the apparent difficulty grandmother found in completing the forms, and her preoccupation with tensions with a current male partner who was difficult and unsupportive, particularly towards any support for Bonnie. There was no mention of the grandfather or of domestic abuse at that point. Grandmother did not appear to be adhering to medical advice about Bonnie's apparent asthma, and the

child was not registered with a dentist. Health Visitor found grandmother manipulative and distracting, seeking support for herself. The poor level of information sharing *within* the health service as well as between outside agencies is most apparent here. GP involvement was routine and there is no evidence of specific engagement with this family despite the child having previously been the subject of a child protection plan and therefore requiring informed monitoring and multi-agency liaison.

3.13. The grandmother informed the Children's Centre on August 6th 2014 that she had been forced to leave her home in North West Devon by her current male partner, due to domestic violence and abuse. She had moved between towns twice due to the volatile relationship with her new partner. The Children's Centres in both towns were central to support to the grandmother and Bonnie through this period of disruption. At the point grandmother presented as homeless, the Children's Centre manager involved the local domestic abuse service by phone, and spoke with Children's Social Care, Housing and Police. The local domestic abuse support agency was also involved.

Grandmother and Bonnie were placed in bed and breakfast accommodation and then moved to a privately rented property in her original Devon town. Grandmother completed her own referral to the Children's Centre in the town on 18th August, with acceptance onto the "Pattern Changing" support group for victims of domestic abuse. Grandmother offered different and contradictory explanations of the abuse, finally denying violence from her ex-partner.

There was no history of domestic abuse incidents recorded by Police in relation to the household or the couple. Children's Centre staff were confused by the constantly changing stories, different and contradictory explanations and descriptions offered by the grandmother about her previous relationship, and her own disability needs. However, it was clear that grandmother was disclosing that Bonnie had been in a household where there had been domestic abuse to the point of relationship breakdown. This did not immediately translate into a child safeguarding plan or child protection assessment.

Fourth Period: Investigation of Child Sexual Abuse

3.14. A Social Work "single assessment" was begun on 17th September 2014 following information that grandfather was now in contact with Bonnie's family home, having been thrown out by his current partner following a domestic incident during which the Police were called. It was alleged that grandfather and uncle were caring for Bonnie in the grandmother's home, including bathing her. In the ensuing social work interview, grandmother exposed discrepancies in her explanation and dishonestly attempted to conceal grandfather's presence in the home. Social Worker B was concerned by the contradictions in the explanations offered by the grandmother who appeared to physically distract attention from the issues. There were clear attempts to deny and hide evidence of

the grandfather's presence in the house. There was evidence that the couple were in contact, contrary to the Special Guardianship Order requirements, which grandmother finally admitted. The social worker was very concerned at the apparent disguised compliance by the grandmother.

3.15. On 18th September 2014, grandmother signed a written agreement not to have any contact with the grandfather. An Initial Child Protection Conference was scheduled for 9th October 2014. Bonnie was due her 2-year health review, and grandmother had uncharacteristically missed appointments. When Health Visitor A undertook the 2-3 year review of Bonnie, she heard from grandmother that the child had trouble sleeping and usually came into bed with her. This raised additional concerns that grandfather had been in bed with the child. The Social Worker B, undertaking the assessment, recorded obvious and sustained dishonesty and attempts at distraction and avoidance by grandmother, in stark and complete contrast to the descriptions of her co-operation and trustworthiness of a year earlier.
Grandmother finally admitted she had renewed contact with grandfather, and whilst acknowledging that grandfather had abused her own children, she could not make the link to him now being a threat to Bonnie. Historical records identified the psychological assessment of grandmother as having reduced capacity to protect or meet Bonnie's needs when stressed. It is most probable that the power and influence of the grandfather had significantly changed grandmother's behaviour and ability to protect. In the course of this review, the social workers involved, including the CAFCASS Guardian, have clearly identified the extreme difference in attitude and behaviour of the grandmother between the period of the Special Guardianship Order assessment and the fresh assessment. Research by HMIC suggests:

> *"The control an abuser can have over a woman could persist during questioning…it is important to understand the nature of domestic abuse when the victim may present as a suspect."*
>
> (Justice inspectorates UK HMIC 2014 P 104)

3.15.1. Lesson Seven: The implications of historical domestic abuse and related dysfunctional behaviour are not sufficiently recognised or incorporated into risk assessment and child protection planning. The entire multi-agency history of assessment and support in this case appears to lack specific knowledge of and attention to the core characteristic of this family as being subject to trans-generational domestic abuse. A more informed understanding of the patterns of behaviour of perpetrators and victims, and impact of the culture of power and control dynamics on family relationships would have secured stronger analysis and planning. Specifically, throughout all agency involvement in the life of Child 11, sensitivity to the inter-connectedness between serious domestic violence and sexual abuse would have produced a very different assessment of risk.

3.16. Strategy discussions agreed that the threshold was met for a s47 single-agency investigation, with an immediate plan with the family for Bonnie to be cared for by the maternal great grandparents, no contact with grandfather, and grandmother to be supervised by the great grandparents when away from the house with Bonnie. There is a lack of clarity in the records of other agencies as to the exact requirements of this plan.

3.17. Children's Social Care management on 22nd September 2014 determined that the threshold for care proceedings was not met. There is little record of the rationale by which the legal threshold was considered. Police records suggest that inter-agency strategy discussion took place about receiving Bonnie into voluntary care under s20 of the Children Act 1989 and determined that would be unethical while the family remained committed to offering care. It is unclear as to whether this was suggested to the family. It is clear that the arrangements in September constituted a holding situation, with no medium term plan.

3.17.1. Lesson Eight: Thresholds for statutory intervention, to ensure child protection, should be transparent, accessible and understood by all professionals in all agencies engaged with child protection, with a process for effective challenge and escalation.

A full consideration of the family history would have identified strong concern, and it may be that the judgement was based upon contemporary events alone, ahead of a more complete social work report to the Initial Child Protection Conference planned for October. It was evident that reliance on the increased involvement of the great grandparents could only be a stopgap measure. There was no longer evidence for any confidence in grandmother's ability to protect.

3.18. **A Children's Social Care Family Support Worker** was allocated on Friday 26th September to support and monitor grandmother's care of Bonnie in the family home. On that day, the practitioner reported to the social worker B that, whilst overseeing grandmother undertaking a nappy change she observed Bonnie to have an "unusually sore anus" not attributable to nappy rash. A set of strategy discussions took place, with the Nursery identifying soreness that they had attributed to nappy rash which she had suffered in the past, but that Bonnie had said "ouch" when being washed, unusual for her, and had been uncharacteristically clingy to maternal grandmother the day before.

The nursery said there had been no disclosure from the child. The question of disclosure was later raised in discussion between children's social care and the Police, where the requirement for a disclosure from the child represented an element of the criteria for intervention. Given the child's age, this mechanism would appear ill-considered. The issue of disclosure of sexual abuse must be associated with the age of the child. The expectation of her portraying a clear disclosure of being sexually abused would be unreasonable.

3.19. **That evening, the social worker B wanted Bonnie to be medically examined** due to concerns of significant harm. Neither grandmother nor great grandparents could be contacted by phone. The social worker first contacted the children's ward of the district general hospital, who declined to see the child and referred the social worker to the Police as the appropriate agency for decision and appropriate referral. The social worker spoke with Police Officer A by phone who was not satisfied that the level of concern necessary for examination had been reached. He suggested she check with the nursery.

In the late afternoon, telephone discussions between the social worker and Police Officer B from the Child Abuse Investigation Unit concluded that there could be no involvement on the Friday evening, as there was insufficient grounds for urgent action given there was no allegation and no disclosure, and the nursery had concluded the marks were "normal" nappy rash. She did not think it appropriate for the child to be subject to an "invasive procedure" based upon this level of evidence. Social worker B's level of concern was informed by the history of the family, and in particular the perceived threat from grandfather, and the proven dishonesty of the grandmother, as well as the marks to the child. In the course of this review, the events of the weekend have remained unclear, with minimal written reports recorded by agencies.

The Police criteria and threshold for joint investigation and engagement with a forensic examination at the Sexual Abuse Referral Centre (SARC) required a higher degree of evidence of abuse than that of Children's Social Care. This represented a professional disagreement for escalation through the multi-agency professional differences protocol.

3.19.1. Lesson Nine: lead agencies engaged in child protection must ensure clear guidelines and advice to their practitioners on the procedure for a forensic examination of a child where there are concerns of sexual abuse:

Sexual Abuse investigations are expected to be a joint process between statutory social work and the Police, and shared understanding of thresholds for action must be agreed. There is clear evidence here of a lack of clarity of the procedure for a forensic examination of a child where there is concern about sexual abuse.

The NSPCC notes

> "…the developmental constraints in the individual child, alongside the missed opportunities to intervene where there is a failure to notice signs and signals" (2014, p48).

Being alert to the potential for sexual abuse requires consideration of the child's behaviour, especially any harmful sexualised behaviour, and emotionality responses alongside any physical marks of concern. Knowledge of family history is also important.

3.20. The social work intervention was passed to the Out of Hours Team, who liaised with the Police at 19:45 hours on the Friday evening, and determined that no action would be taken as the child would be likely to be asleep in bed and there was insufficient evidence to warrant action. Police Officer B later explained that a strategy discussion had concluded that the criteria had not been met for a forensic examination of the child because there was no disclosure or allegation. Social Worker B was not able to contact grandmother by phone. The local authority's Emergency Duty Team for social care undertook to contact grandmother to ensure she took Bonnie to the family general practitioner the next day (Saturday) and for the Police to undertake welfare checks concerning the whereabouts and activities of the grandfather. In the course of this Review, Police representatives have identified the crucial breakdown in communication between children's social care and the Police, where historical information appears only to have been shared at the later medical examination of Bonnie, preventing clear decision making. At the same time, officers in the Child Protection Unit confirm that they routinely undertook intelligence checks, including about the parents, and records should have identified the grandfather. However, in this period, no less than three separate databases were in place and not all information concerning the family would necessarily have been seen. Police recording of the incident clearly identify that they did not know the full facts about the history of the child, grandparents or family at the time.

3.21. **The Out-of-Hours Emergency Duty Team** undertook further liaison on Saturday 27th September and recorded that they were restricted in their intervention in the absence of a disclosure from Bonnie. They had passed responsibility to the Police to contact grandmother, and were advised that hospital paediatricians were not agreeable to examine for sexual abuse as this should be a forensic process. All three core services agreed that there was not enough information to warrant a forensic medical examination. In the event, there is no evidence of contact with grandmother over the weekend, and the grandmother did not take Bonnie to the family doctor or local minor injuries unit. Bonnie was not seen by any agency.

3.22. **Children's Social Care continued investigations on Monday 29th September,** including strategy discussions with various agencies. Police recorded no evidence that grandfather was living at the address. Discussion between Children's Centre and Nursery shared information about the level of concern expressed by the social worker before the weekend, and of the need for heightened vigilance. Bonnie was at nursery as usual and the staff reported a nappy rash and "nothing untoward". This review has heard sufficient practitioner observations to clearly evidence a reluctance across all agencies, including general health services, to take ownership of the identification of signs and symptoms of sexual abuse.

In the multi-agency discussions with those active in this case at the time, all concerned recognised the issue of confidence to make judgements about sexual harm, wishing instead to have "expert" diagnosis. When compared with the level of confidence in the identification of neglect, physical abuse or emotional harm, the preparedness to own the identification of sexual abuse and take responsibility for taking action is far less.

The NSPCC's research into social work confidence in this area offers insight into the multi-disciplinary issues:

> "Social workers' confidence in working with sexually abused children is influenced by a number of important variables. These included social workers' access to training, peer and managerial support and supervision, experience of managing cases of child sexual abuse and previous experience of direct work with sexually abused children."[3]

[3] https://www.nspcc.org.uk/globalassets/documents/research-reports/social-workers-knowledge-confidence-child-sexual-abuse.pdf

(NSPCC, 2014. p6)

3.22.1. Lesson Ten: Signs and Symptoms of sexual abuse, including the nature of disclosure in childhood, must be understood by all practitioners engaged in contact with children and/or their families. In this case, the reliance upon forensic medical examination to identify sexual abuse, and the reluctance to commission the examination, resulted in a significant delay to due process. Confidence to recognise signs and determine immediate safeguarding action appeared low. This must represent, not only the poor knowledge and understanding of signs and symptoms, but also the values and attitudes of individuals and agencies relating to child sexual abuse and harmful behaviour.

Evidence from records in this case, and from discussion with the practitioners involved, suggest a lack of confidence in undertaking assessment or taking action where there is concern for child sexual abuse, without referral to specialist assessment. Further exploration is needed to understand the difficulties and challenges that practitioners face in respect to identifying indicators of sexual abuse.

3.23. Wednesday 1st October, both the nursery and Children's Centre reported significant abrasions and bruising to Bonnie's genitals and anus. The Police Officer B discussed the new information with children's social care, and with the Forensic Medical Examiner from SARC. Grandmother agreed for the examination to take place. The child was seen that day by the Forensic Medical Examiner at the SARC service. The SARC identified clear evidence of significant sexual abuse and physical harm, and reported that the timing of the examination was crucial for both identification and treatment. Without her decision to proceed, the professional disagreement with the Police could have prevented the child from being protected at that stage. As a direct result of involvement with this case, the Forensic Medical Examiner recommends that the SARC should be more informed and engaged with strategy discussions at an early stage.

3.24. Sexual Abuse Referral Unit procedures at the time (see Appendix Two) identify that the Police are responsible for referral for medical examination out-of-hours at weekends, in consultation with social services, for examination to take place in a hospital setting. In this case, it is clear that the Police considered the criteria for referral not met and referral was not made. Due to changes to agency responsibilities, the referral process has been updated in 2015 (see Appendix Three), identifying a joint process for referral. The SARC manager has confirmed that social workers can make a direct referral to the SARC.

This review has identified the lack of clarity of purpose and value of the SARC, and lack of shared understanding between agencies as to the process of consultation and referral. It remains unknown but likely on the basis of subsequent events that had Bonnie been examined on the night of the 29th she would have been removed from the family home and related danger at that stage.

3.24.1. Lesson Eleven: The criteria for referral to the local Sexual Abuse Referral Centre should be clear for all agencies and practitioners, with a known pathway for professional consultation and advice.

It remains unclear as to responsibilities within the Health Services for accepting a referral and undertaking an examination out-of-hours and at weekends. In addition, the SARC team are concerned that there may be a reluctance by professionals to refer to SARC because of a false understanding of the process of medical examination as invasive and potentially traumatic to the child and family, which is not the case.

This "reluctance to refer" may take the shape of a subjective threshold level applied on a case-by-case basis to determine a sufficiency of severity. There is no such threshold. Referral for paediatric observation, discussion and where necessary, examination, should be an accessible service to agencies concerned for the welfare and protection of children and young people.

3.25. Bonnie was taken into care and temporarily placed with her maternal great grandparents on 3rd October 2014, with a subsequent Placement Order for planned adoption.. There were significant delays in the Police process for investigating this abuse, including arrests of the grandparents, and no charges have been brought. It remains unclear as to how the child had been sexually abused or by whom**.**

4. Summary and Conclusions

4.1. Family History: the history of abuse and alleged abuse between family members, when taken together, suggest a significant level of risk to children. At all stages of the pregnancy and young life of Bonnie where an agency or agencies undertook assessment of risk in the family, stronger *analysis* of family history in the assessment should have ensured recognition of patterns of risk-taking behaviours and evidence of absence of emotionally intelligent responses to crisis by family members. The quality of an assessment must be judged upon the level of analysis based upon knowledge of family dynamics and child development.

4.2. Special Guardianship Order: The pattern of abuse and harm in the family should have produced an analysis reflecting far higher risk than was apparent in the Special Guardianship Order report. There was evidence that grandmother was in charge of her own life at the time of the assessment, and some evidence of a bond and ability for adequate care of Bonnie. This appears to have influenced the analysis of risk and down-played the importance of the significant historical patterns of abusive relationships and behaviour within the family. Whilst practitioners are expected to consider family solutions in such cases, the best interests of the child should be paramount which may not always be achieved by a placement within the extended family

The protective factors in the report relied upon the grandmother's future compliance with the social worker and her apparent full separation from her ex-husband. Even so, it made no reference to the general vulnerabilities of victims of domestic abuse, the proven links between domestic abuse and sexual harm, or the continued threat from perpetrators after leaving the family home.

At the same time, the structure of the Report, detailing each family member's assessment one after another, obscured the historical events and inter-personal dynamics that should have caused greater concern. The reliance upon a long term plan and complex set of recommendations for multi-agency support was probably unreasonable for the family and unmanageable for Children's Social Care.

4.3. Restructure of Children's Social Care: key periods of assessment and decision-making took place during significant structural change, changes to systems, roles and responsibilities, and changes in personnel. There are lessons here for effective strategies for institutional management of change, including risk assessment ahead of implementation.

4.4. Information Sharing: there was good liaison and information sharing between the social worker A and the Guardian – the two key professionals responsible for the assessment of placement of Bonnie with her grandmother. Whilst collaboration between the adult services (Disabilities Team) and children's social care was poor, there was sufficient information sharing given the detachment of mother from Bonnie. The most important moment for the protection of the child, on the afternoon and evening of Friday 26th September 2014, exposed significant historical and contemporary failures in information sharing between a range of key services, and between children's social care, Police and the SARC. The poor communication was emphasised by the nature of this case where multi-agency understanding of the complex family history should have alerted all agencies to heightened sense of

urgency. No-one had a clear picture of what was happening in the family. The drift and delay in action to protect the child was the result of inadequate information sharing.

4.5. Disguised compliance and the Rule of Optimism: the professional trust relationship between Social Worker A and the grandmother was wholly contradicted by the later behaviour and character of grandmother during the period of re-assessment and concern of sexual abuse. Social Worker B clearly identifies the attempts by grandmother to distract from focus upon the risks to the child, and her significant inconsistency in explaining her home circumstances. The CAFCASS Guardian also identifies the significant difference in the behaviour of grandmother between the period of the Special Guardianship Order and the period of sexual abuse investigation. It is not possible to determine the extent to which grandmother disguised the conditions at the time of the Special Guardianship Order assessment. An informed level of understanding of patterns of behaviour in victims of domestic abuse would inform an assessment of the difference in capacity during periods of stability and absence of threat, and a period where the perpetrator was present in the family home. The grandmother's later behaviour offers strong guidance to professionals engaged in assessment of risk that continued respectful curiosity and professional scepticism is a vital element of child protection.

4.6. Adult Centricity: Throughout this Review there is an undercurrent of professionals being diverted towards addressing the needs of the adults over the need of Bonnie. The assessment of the grandmother for the granting of the order recognised significant risks but did not then guide the agencies to comparing a family placement with other care options. The mother's difficulties distracted from any assessment of her level of contact with the family home and impact upon the child. The grandmother's self-identification of literacy difficulties and domestic abuse were not considered in respect of the impact on the child. The guiding principle of the Children Act 1989, that the child's interests are paramount", are not borne out in practice here.

4.7. Knowledge of and confidence in professional roles and responsibilities The apparent poor understanding of the SARC function is identified as a significant barrier to early engagement and potential early identification of risk of sexual harm. The use of the escalation policy is inadequate.

4.8. Inconsistencies in the identification of Signs and Symptoms of sexual abuse including disclosure in young children: The nursery staff were strong on the mechanisms for monitoring and recording of concern, and information sharing. However, there is evidence that clarity around signs and symptoms of sexual abuse, and the difference between those physical signs and nappy rash, caused some delay in the safeguarding of Bonnie The first stated concern was considered as nappy rash. A discussion did occur involving concepts of disclosure which were inadequate – both the nursery staff and the Police sought confirmation of the genital soreness by seeking "disclosure" by the 2 year old child, a very flawed approach at this age, and very unclear as to any shared understanding of what type of disclosure was being sought.

5. Considerations for the Board

The following questions are offered as considerations for members of the Devon Safeguarding Children Board in the light of the findings of this Review. These considerations should form the basis of the Action Plan for securing assurance from partner agencies. The Board may consider that the Board has sufficient current evidence to answer a question without further action, and may determine other actions not raised here.

5.1. Domestic Abuse

5.1.1. Is there evidence of a good level of understanding of the signs and symptoms of domestic abuse amongst practitioners working in key agencies which offer support or advice to families, including recognition of historical indicators of current levels of risk? (Lesson Seven, Item 3.15.1., p.18)

5.1.2. Is there evidence of a joined-up approach, including early and effective information-sharing, between services for adults and services for children to the identification and prevention of domestic abuse in families?

5.1.3. Is there a culture of optimism in relation to Domestic Abuse, caused perhaps by the current levels of abuse identified in families in contact with statutory services? (see also Lesson One, 3.5.1, p.10)

5.2. Assessment of Child Sexual Abuse

5.2.1. Is there sufficient evidence of a good level of understanding by lead agencies in Devon of *signs and symptoms* of child sexual abuse, including the implications from signs of other forms of abuse, such as domestic violence, for the risk of child sexual abuse? (Lesson Ten, 3.22.1., p.21).

5.2.2. Is there a satisfactory level of *assessment of risk* of child sexual abuse, including a sufficient level of consideration of extended family history, by lead agencies in Devon today compared with 2013, and what evidence can be produced to show this?

5.2.3. Is there an institutional *culture of diligence* towards the investigation of child sexual abuse, and are the professional attitudes and values expressed by lead professionals in Devon sufficiently informed about the impact of child sexual abuse on family members, including

i. Sufficient concern and due diligence in consideration of risk,
ii. understanding of characteristics of victim disclosure at the different stages of child development, and
iii. recognition of the Accommodation Syndrome (Summit 1983, et al) which reduces the likelihood of child victims speaking of their abuse, and increases the likelihood of later retraction of disclosures?

5.2.4. Are Police investigations into child sexual abuse in Devon, and the associated pursuit of perpetrators towards successful conviction, adequate?

5.2.5. Are there sufficient requirements in place for supervision of cases involving the safeguarding of children or young people to ensure challenge of the professional assessment and analysis to prevent both fixed hypothesis and a rule of optimism? (see Lesson Two, Item 3.7.1., p.11)

5.2.6. Are there sufficient services for specialist therapeutic support for victims of child sexual abuse in Devon?

5.3. Special Guardianship Orders

5.3.1. Does the current structure of Court Reports relating to application for a Special Guardianship Order offer a sufficiently joined-up picture to ensure clear and unambiguous oversight of relationships and level of risk posed by extended family members?

5.3.2. Is there sufficient evidence that the Devon Special Guardianship Team is ensuring a good level of monitoring and support of the order of the Court and multi-agency support planning following the granting of an Order? (See Lesson Three, 3.8.1., p12).

5.3.3. Is there an evidence of agency or Court bias in decision-making towards keeping a child with their natural family as the dominant criteria over and above ensuing the child's best interests remain paramount?

5.4. Multi-Agency Child Protection Systems

5.4.1. Do partner agencies have tested systems in place to ensure multi-agency *system impact assessments* are undertaken before major planned change is enacted involving internal (single-agency) structures, procedures, service thresholds and/or delivery? (Lesson Four, 3.9.1., p.13)

5.4.2. Are there good levels of multi-agency information-sharing where there is early concern for the welfare of a child, and is that information maintained at a timely and effective level throughout the period of concern? (Lesson Five, 3.10.1., p14).

5.4.3. Do the services for children and the services for vulnerable adults collaborate effectively to ensure a joint approach to the identification and response to identified risks and needs in the family, with good information sharing in practice? (Lesson Six, 3.11.1., p.15).

5.4.4. Is the criteria for legal planning and application by Devon County Council sufficiently transparent and understood by practitioners and managers in lead agencies engaged with child protection? (Lesson Eight, Item 3.17.1., p.18).

5.4.5. Is the escalation policy regarding the process for resolution of professional differences well understood and managed across partner agencies?

5.5. The Sexual Abuse Referral Centre

5.5.1. Is there a good level of knowledge across lead partner agencies of the work, purpose of and access to the Sexual Abuse Referral Centre? (Lesson Eleven, Item 3.24.1., p.22).

5.5.2. Are there shared thresholds in place detailing the criteria for referral to the SARC, understood in practice across all lead agencies? (Lesson Nine, Item 3.19.1., p.20).

5.5.3. Is there clarity across partner agencies for the process of referral into the SARC?

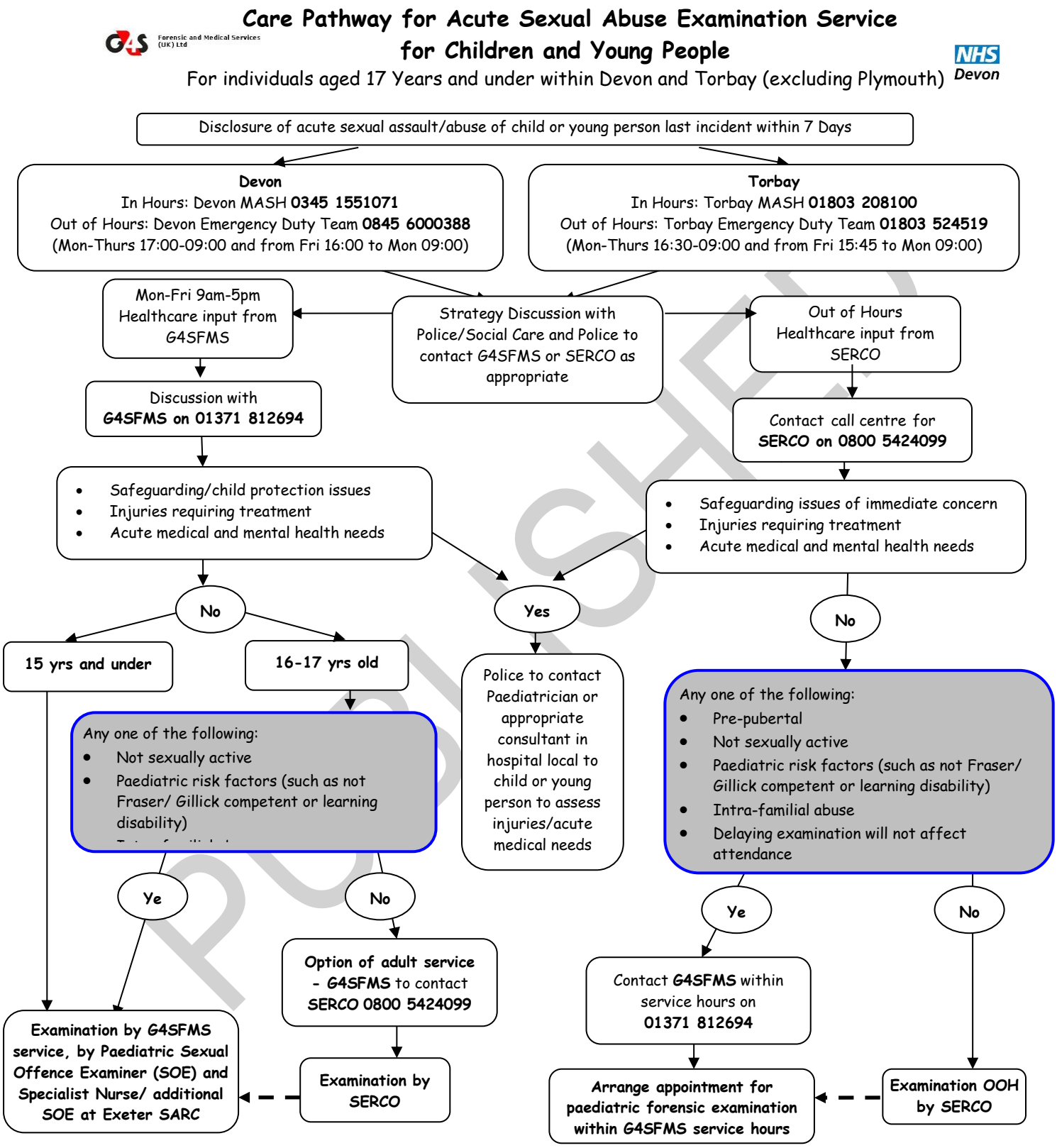
END

Appendix One:

Glossary of Terms

CAF	Common Assessment Framework is an early help inter-agency assessment. It offers a basis for early identification of children's additional needs, the sharing of this information between organisations and the coordination of service provision. CAFs should identify what help the child and family require to prevent needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act 1989. The findings from the Common Assessment may give rise to concerns about the child's safety and welfare. In these circumstances, it should be used to support a Referral to Children's Social Care. Undertaking a CAF is not a pre-requisite for making a referral. [See https://www.gov.uk/topic/schools-colleges-childrens-services/looked-after-children]
CAFCASS	The Children and Family Court Advisory and Support Service represents children in family court cases, and is independent of the courts, statutory authorities and similar agencies, representing the child's best interests to the court. [Access: http://www.cafcass.gov.uk
CiN	A Child in Need is defined by Section 17 of the Children Act 1989, as interpreted by the Local Authority in which the child resides.
DASH	Domestic Abuse, Stalking and Honour based Violence risk assessment tool [Access: http://www.dashriskchecklist.co.uk/uploads/pdfs/DASH%202009.pdf]
DCC	Devon County Council [Access: https://new.devon.gov.uk]
MARAC	Multi-Agency Risk Assessment Conference is part of a coordinated community response to domestic abuse. [See Devon MARAC]
s20	Section 20 of the Children Act 1989 identifies the duty of the Local Authority to provide a child with somewhere to live because the child doesn't have a home, or a safe home.
s47	Section 47 of the Children Act 1989, requires the local authority to undertake investigation where there is suspicion of significant harm to a child.
SARC	Sexual Abuse Referral Centre. Commissioned by NHS England, includes a forensic suite for assessment of sexual abuse.
SGO	Special Guardianship Order: an order appointing one or more individuals to be a child's 'special guardian'. It is a private law order made under the Children Act 1989 and subject to the Special Guardianship regulations 2005, currently the subject of review. [See also: https://www.gov.uk/government/publications/special-guardianship-guidance]

Appendix Two – SARC Acute Care Pathway at time of Bonnie



Represents scenario where additional information is acquired by the SOLO/SOE after call has been allocated, i.e. paediatric risk factors previously thought to be absent have now been identified. This may deem it more appropriate for the individual to be seen within paediatric service and therefore the pathway allows for referral back to G4SFMS service. It is anticipated this scenario will be *very rare*.

Paediatric forensic examination, includes paediatric assessment, recovery of forensic evidence, colposcopic examination, interpretation of ano-genital findings, management of injuries, medical aftercare management, discussion with Child and Young Persons Services/social care regarding safeguarding concerns, liaising with Police, informing GP and referral for psychological support together with consideration of NHS community paediatric follow-up, including out-patient clinic local to individual. Onward referral of individuals will be made as appropriate.

Care Pathway for Acute Sexual Abuse Examination Service for Children and Young People

Forensic and Medical Services (UK) Ltd

NHS England

For individuals aged 17 Years and under within Devon and Torbay (excluding Plymouth)

Disclosure of acute sexual assault/abuse of child or young person last incident within 7 Days

Devon
In Hours: Devon MASH **0345 1551071**
Out of Hours: Devon Emergency Duty Team **0845 6000388**
(Mon-Thurs 17:00-09:00 and from Fri 16:00 to Mon 09:00)

Torbay
In Hours: Torbay SG Hub **01803 208100**
Out of Hours: Torbay Emergency Duty Team **01803 524519**
(Mon-Thurs 16:30-09:00 and from Fri 15:45 to Mon 09:00)

Mon-Fri 9am-5pm
Contact Sexual Abuse Assessment Service for Children & Young People
01371 812600

Strategy Discussion
between
Police, Social Care and Health.

Out of Hours
Healthcare input from Adult Sexual Offence Service
Contact **G4SFMS** call centre
01371 812600

Discussion
- Safeguarding/child protection issues
- Acute medical and mental health needs, including injuries requiring treatment

Discussion
- Safeguarding issues of immediate concern
- Acute medical and mental health needs, including injuries requiring treatment

Acute medical needs

No acute medical needs

No acute medical needs

Contact Paediatrician or appropriate consultant in hospital local to child/ young person to assess injuries/acute medical needs

Any one of the following:
- Pre-pubertal
- Not sexually active
- Paediatric risk factors (such as not Fraser/ Gillick competent or learning disability)
- Intra-familial abuse
- Delaying examination will not affect attendance

Yes

No

Examination by G4SFMS Sexual Abuse Assessment Service for Children & Young People at SARC in Exeter

Paediatric Sexual Offence Examiner (SOE) and Specialist Nurse +/- additional clinician depending case complexity

Arrange appointment for paediatric forensic examination by G4SFMS Sexual Abuse Assessment Service for Children & Young People within service hours

Examination OOH by FME if in indicated from factors relating to case or young person

← – – Represents scenario where additional information is acquired by the SOLO/SOE after call has been allocated, i.e. paediatric risk factors previously thought to be absent have now been identified. This may deem it more appropriate for the individual to be seen within paediatric service and therefore the pathway allows for referral back .

Paediatric forensic examination, includes paediatric assessment, recovery of forensic evidence, colposcopic examination, interpretation of ano-genital findings, management of injuries, medical aftercare management, discussion with Child and Young Persons Services/social care regarding safeguarding concerns, liaising with Police, informing GP and referral for psychological support together with consideration of NHS community paediatric follow-up, including out-patient clinic local to individual. Onward referral of individuals will be made as appropriate.

Appendix Four – Terms of Reference

SCR Case: CN 11

1. Overall Aim of SCR / Management Review

The purpose of a SCR / Management Review is to:

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

SCRs and Management Reviews should be conducted in a way which:

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

Working Together to Safeguard Children (2015) p74

2. The SCR and Disciplinary Processes

SCRs are not part of any disciplinary process. However, should information emerge in the course of the review that may indicate disciplinary action should be taken, individual agencies should consider their own procedures.

3. The Reason for the SCR

Bonnie was subject of Care Proceedings in DCC, which concluded in 2013 with an Special Guardianship Order to maternal grandmother (MG). These Care proceedings had included concern in regards to risk of sexual abuse from the Maternal Grandfather. The Special Guardianship Report made reference to MGM's lack of capacity to appreciate the risk of harm that is posed to children by MGF. Information within the Psychological Report in respect of MGM identified that her capacity to be attuned to Bonnie's needs is much reduced when MGM is stressed. A referral to MASH advised that MGM had allowed MGF to move into the family home. The outcome of the strategy meeting was a single agency S47 assessment. The case progressed to an ICPC and an agreed written plan was signed that no contact was to be facilitated between Bonnie and MGF. The Family Practitioner observed Bonnie having a nappy change and alerted the social worker to concerns about soreness around Bonnie's bottom. A decision was made agreeing that in the context of concerns regarding sexual risk it was appropriate to request that Bonnie attend for a medical. For several reasons this medical did not happen and concerns were raised again following a further observed nappy change on by the nursery and the Children Centre. There was initially a reluctance to progress a SARC forensic

medical examination, but following escalation, the medical was undertaken and concluded that Bonnie had sustained injuries that were indicative of her having suffered sexual abuse. The Local Authority obtained an EPO.

The decision of the Chair was that Bonnie had suffered significant harm and there are concerns about the multi-agency work to protect Bonnie, therefore, the case met the criteria for a SCR and would be undertaken as a one day event focusing on how agencies work together to properly assess and protect children who are at risk of or have been subjected to being sexually abused.

4. The Scope of the SCR

The review will cover the period from 1st October 2012 until 2nd October 2014; this is the period starting with The Local Authority completing a Special Guardianship Assessment and concluding with the EPO being obtained.

The review will focus on:

- the assessments and analysis of the risks identified
- why the medical was not undertaken in a timely manner
- agencies communicating with each other
- information sharing
- do all agencies know the signs and symptoms of sexual abuse to look for
- challenging of other agencies
- understanding around the requirement for disclosure in very young children

And in light of the above the review must have a view whether the abuse could have been prevented.

The following agencies were involved in the child protection process:

Children's Services	Devon & Cornwall Police
Children's Centre	Cafcass
Nursery	SARC
Virgin Care	GP

5. Methodology

All the professionals involved with the case will meet up for a one day event which will be facilitated by a reviewer appointed by the DSCB. The review will incorporate Social Care Institute for Excellence (SCIE) multi-agency systems approach as well as appreciative enquiry methodology to explore key practice episodes which will have been identified by the SCR sub group.

6. Quality Assurance

The Lead Reviewer(s) will be supported by the SCR Subgroup throughout the course of the review who will assure the quality of the work.

7. Involvement of Family Members in the SCR / Management Review

The Lead Reviewer(s) will agree which members of the family are to be approached to be involved in the review and necessary support requirements for them to ensure participation.

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