NORTHUMBERLAND SAFEGUARDING CHILDRENS BOARD

SERIOUS CASE REVIEW USING THE

SIGNIFICANT INCIDENT LEARNING PROCESS

MOLLY

Confidentiality statement

This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the NSCB/SCR chair.

The disclosure of information (beyond that which is agreed) will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved

INDEPENDENT REVIEWERS:

Mark Dalton
Nicki Pettitt

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1. INTRODUCTION

Introduction to the Serious Case Review

1.1 Molly was 4-years-old when it became known that she was the victim of sexual assault by her mother's partner. In December 2015 Molly told her mother and social workers during a child protection enquiry that mother's partner had taken her into a room and hurt her. At the time of the disclosure mother and her partner were living apart.

1.2 Mother's partner was convicted on numerous counts of rape and other sexual offences involving Molly and others. He was sentenced to 18 years in prison in April 2016.

The Decision-Making Process

1.3 The circumstances were considered against the criteria set out in Chapter 4 of Working Together to Safeguard Children 2015:

1.4 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCB's. This includes the requirement for LSCB's to undertake reviews of serious cases in specified circumstances. Regulation 5(1) I and (2) set out an LSCB's function in relation to serious case reviews, namely:

> 5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
> (2) For the purposes of paragraph (1) (e) a serious case is one where:
> (a) abuse or neglect of a child is known or suspected; and
> (b) either (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.
>
> Where a case is being considered under regulation 5(2)(b)(ii), unless there are no concerns about inter-agency working, the LSCB must commission an SCR.

1.5 In this case a child had been seriously harmed and abused. There was also some concern about the quality of interagency working between different agencies.

The Key Principles of the Significant Incident Learning Process (SILP)

1.6 The key principle of SILP is the engagement of frontline staff and first line managers as active participants in the review process, alongside members of the Children Safeguarding Board Serious Case Review Panel, and Designated and Specialist Safeguarding staff. The engagement of frontline staff and first line managers enables a higher level of involvement in the review process and therefore a much greater commitment to learning and dissemination of the lessons from the review.

1.7 The process focuses on understanding why individuals acted in a certain way. It highlights the factors in the system that influenced their decision making at the time. The review process is separate from any potential grievance process or disciplinary action, but seeks to promote open and transparent learning from practice and improve inter-agency working. It also highlights what is working well and examples of good practice.

1.8 This engagement comprises:

- Independent Management Reports (IMR's) being commissioned from all the agencies/providers engaged with the subject of the review during the period under review. This identifies the single agency learning and any recommendations for improvement.
- Learning Events involving many of the practitioners, managers involved directly in the case, along with Safeguarding Lead Professionals coming together for a day to discuss the case.
- All the IMR's being shared with the participants at the Learning Events,
- A draft Overview Report which critically reflects the management reviews and includes the comments and perceptions of the participants in the Learning Event,
- A second Learning Event at which the first draft of the Overview Report is debated.

THE PROCESS

Terms of Reference

See appendix 1

Engagement with the family

1.9 Molly's mother met with one of the independent reviewers and a representative from Northumberland Safeguarding Children Board during this review and discussed the events leading to the discovery of the abuse of her daughter. The final version presented to the Northumberland LSCB will be made available to her prior to publication.

Background information

1.10 Molly's family first moved to Northumberland in February 2014, at that time the family comprised, Molly, her mother, and mother's partner. The relationship with Molly's birth father had ended and the relationship between Molly's mother and her new partner was relatively new; they had only been in a relationship since January 2014.

1.11 The family registered with two separate GP practices in a relatively short period; the change of practice being the result of a change of address. They became known to Northumberland Health Visiting Services in February 2014. A Tynedale Health Needs Assessment[1] was completed which recorded that Mothers previous relationship with Molly's father had been abusive. Mother also shared that she had been distressed by some text messages from her ex-partner and was worried he now knew where she lived. The Health Visitor provided advice which included the contact details of agencies which could offer additional support. The usual screening questions about any current issues of domestic abuse were not asked as mother's partner was present at the interview. Molly's mother was the younger of two siblings and had a history of depressive illnesses and other health problems. The most important relationship was with her own mother, who was seen as a source of support at the time, but someone who could also dominate Molly's mother and has significant health needs of her own.

1.12 The family transferred to a second Health Visitor in March 2014 because of their change of address. A second health needs assessment was completed, but again questions about any current domestic abuse were not asked as the partner was present during the interviews. There were no other concerns raised by the assessment.

1.13 In July 2014 Molly was taken to the GP with a rash and soreness to her genital area, a problem which had lasted intermittently for two weeks.

[1] Tynedale Health Needs Assessment Tool (THNAT) is a structured assessment tool which covers nine specific areas, including socio-economic factors, parental health, substance abuse and domestic violence, previous children, parents' experience of childhood and family life, support, coping mechanism, and interests.

The GP prescribed medication for thrush. This was the first presentation of a symptom that would re-occur several times in the next year.

1.14 The first contact with Northumberland Children's Services occurred in August 2014 following a referral from the Crisis Resolution and Home Treatment Team[2] relaying concerns about maternal grandmother. The Crisis Team reported that maternal grandmother had full time care of Molly and they were concerned about her state of mind. Maternal grandmother also stated that her relationship with her partner was under stress. A referral was made to Children's Services who contacted Molly's mother, she told Social Workers that Molly lived fulltime with her and her partner and only stayed occasionally with maternal grandmother.

1.15 Mother and her partner were invited to the office to discuss the Crisis Teams' concerns. The couple were offered advice about how witnessing abusive behaviour could impact on children but no further role for Children's Services was identified. This intervention was recorded on an information and advice record; which meant that no home visit or direct assessment of Molly undertaken. The Health Visitor was still marginally involved and discussed the case with Children's Services on several occasions.

1.16 In November 2014 Moly was seen again by the GP with a recurrent rash on her inner thighs and 'clicking' hips. An irregular rash was noted over her thigh and buttocks. No explanation was discussed regarding this and the GP was more concerned about the reported 'clicky' hip. The hip problem was later assessed by the health visitor in the home environment. Although Molly's mother and her partner reported that Molly cried with pain if she walked any distance and complained of soreness, the Health Visitor observed Molly running, walking, and climbing with ease.

1.17 Molly's sibling was born in November 2014. The pregnancy had been uneventful and all anti natal appointments were kept. However, by the six weeks' post-natal check, Molly's mother admitted to feeling low and stated she had suffered post-natal depression following her previous pregnancy (Molly). The family had moved home two days prior to the birth which had been stressful.

1.18 The Health Visitor arranged an appointment with the GP in January 2015. The GP consultation did not explore in any depth why Molly's mother was depressed. There is nothing documented in the GP records to demonstrate how mother's low mood/depression impacted on her parenting skills and ability to cope with two very small children at home. The GP records noted that the 'husband' was helping with house chores

[2] The Crisis Resolution and Home Treatment Team is a team which offers assessment and home treatment for people experiencing a mental health crisis.

and prescribed anti-depressants for Mother. Other options were also explored such as counselling and further Health Visitor support. The GP agreed to see her again in two weeks, however there was no follow up appointment and mother was not seen again for over three months.

1.19 There was some family support from the maternal grandmother who lived close by, although this was not without its own difficulties as she was contending with her own personal challenges. In February 2015, the Health Visitor began fortnightly 'listening visits' and became concerned as mother was quiet, not eating much, difficult to engage and had run out of anti-depressant medication.

Practice Messages – Background information

1.20 The lack of an accurate record of the status of mother's partner by both GP practices is an important oversight; he was variously referred to as "father", "husband", "boyfriend" and "partner". The first practice also assumed that he was Molly's birth father. If accurate baseline information is not collected at the point when patients register, then inaccuracies can assume the status of "facts".

1.21 Neither the GP or Health Visitor considered the history of the rash in July 2014 followed by presentation with rash to inner thighs and buttocks in November 2014 as being a possible cause of her soreness. It is possible that that the second GP was unaware or the earlier presentation. The focus was on Molly's hip pain as being the main cause for concern; this is understandable because joint symptoms in young children can potentially be serous and need to be investigated.

1.22 In the light of subsequent events, the significance of the individual and family histories of Molly's parents became more apparent. It subsequently became known that Molly's mother's partner was the oldest of 4 children, and there had been previous concerns about him displaying sexually harmful behaviour and alleged sexual assaults on other young females. The victims in all cases withdrew their complaints. Records indicate that he had a learning difficulty, and was known to have problems controlling his temper when he was growing up. Although this did not prevent him working, it would seem he had difficulty in establishing personal relationships and was something of a loner.

2. KEY EPISODES

2.1 The SILP methodology has adapted the term "key episodes" from the systems approach to Serious Case Reviews developed by the Social Care Institute of Excellence (SCIE). A key episode can be a single event or a series of events over time where there were key changes in the circumstances of the case which require further analysis.

2.2 A key episode can be good or problematic and the use of the word "key" emphasises that this is not a list of every event in a person's life; rather it is intended to shine a light on those professional involvements which seem significant in understanding the decisions made at the time.

2.3 Inevitably there is some overlap between key episodes, due to the complex interface between different services.

KEY EPISODE 1 - Liaison between Police Scotland and Northumbria Police June 2014

1st occasion - June 2014

2.4 An email contact from Police Scotland in June 2014 was the first-time Northumbria Police were aware of mother's partner living in the area. The initial email request was for assistance in tracing mother's partner regarding ongoing enquiries into sexual offences.

2.5 The request was straightforward; confirmation of his current address and to obtain contact details for him. The Northumbria Police Inspector made direct contact with his Scottish counterpart who confirmed that they believed mother's partner was in a relationship with her. There was no expectation that he should be arrested at this point.

2.6 The emails between the Detective Constable in Scotland and the Inspector in Northumbria on 4th June 2014 show that the full extent of mother's partner's sexual offending, (which included two charges of rape, one attempted rape and a sexual assault against a child) was shared with Northumbria Police. However, this information was not given to the Police Officer sent to the family home to check whether he lived at that address.

2.7 The visit was somewhat routine, Molly's mother stated she was fully aware of the allegations against her partner, but believed that they were untrue, and motivated by an ex-girlfriend trying to get him into trouble. At the time of the enquiry, the Police Officer was not aware of Molly and no mention of her was made to the Officer during his conversation with Molly's mother.

2.8 Following confirmation of the address Police Scotland (with the assistance of Northumbria Police) arrested mother's partner on 12th June 2014 on suspicion of rape of a female aged 16 or over. He was taken back to Scotland and charged with rape and released on bail without conditions or residency monitoring.

Practice Messages – Key Episode 1

2.9 The quality of the liaison between Police Scotland and Northumbria Police was significant because it concerned the transfer of information regarding the potential risk Molly's mother's partner may pose to children. The context of the information exchange was an attempt by Police Scotland to ascertain mother's partner's whereabouts to investigate alleged sexual offences in Scotland.

2.10 However, during the exchanges neither Police Force appears to have considered that mother's partner may pose a risk to Molly or her unborn sibling. His previous history of abuse and offences against children appears to have been overlooked in assessing risk.

2.11 The system for exchanging emails at "Force level" is one where emails are sent to a Force-wide hub and then distributed to the relevant district and subsequently allocated to an officer who is then responsible for that piece of work. Once work has been delegated through the chain of command, individual officers communicate freely between Police Forces to clarify information and report progress. Although important details were shared, the information was not subject to any analytical discussion that might have led to a strategy to manage the risks posed by mother's partner. On this occasion, important details concerning mother's partners offending history were not passed down the chain of command, and the primary task of locating him subsumed any wider concerns about the potential risk he might pose.

2.12 Because Molly's mother was neither a complainant or witness there was no formal mechanism for informing her of the outcome of the court hearing in Scotland. Furthermore, there is no system in place for passing on court disposals between Police Forces; an individual officer needs to be actively monitoring a person to know what their current status is. Because of this Northumbria Police were not informed of the outcome of the hearing in Scotland, or that Mother's Partner had returned to Northumberland without any bail restrictions or residency monitoring.

KEY EPISODE 2 - Injury to Molly 27th April 2015

2.13 Molly was taken to the GP by her mother on the morning of 27th April with symptoms of a genital bleed. There was no obvious injury and after

telephone consultation with a paediatric SHO, a decision was made to refer Molly to the Children's Assessment Suite at the local hospital A&E department. It subsequently transpired that Molly should have been sent to the Paediatric assessment unit at the local general hospital which is where the Paediatricians were based who would review Molly. Molly was later referred to the Paediatric Forensic Network (PFN), a specialist service located at the Regional Hospital some distance from the original hospital.

2.14 The reason for the bleeding could not be conclusively established. On examination, there was some evidence of bruising and a possible injury. Molly also said to the doctor that she may have hurt herself by falling on her shoe, although her speech was indistinct and the doctor could not be sure she had understood Molly correctly. While this may seem unusual, such injuries have been documented previously in other girls, and so this seemed a possible explanation for the cause of the injury. The explanation was also partly confirmed by Molly's mother who said Molly had sandals with a rim around the sole and she had seen blood on them.

2.15 What was unknown to the doctors in different hospitals were the differing descriptions of the discovery of Molly's injury.

2.16 Initially the GP had been told that mother and partner were together with Molly as her nappy was being changed. Mother had gone downstairs for a moment and on her return noticed a "gush" of blood from Molly's vagina. Therefore, in this account it suggests that mothers partner was left alone with Molly for a short time and the blood noticed during a nappy change.

2.17 Later, the nursing and medical assessments at the referring hospital recorded that Mother's partner had gone upstairs and found Molly lying on her changing mat with blood on her hands and bleeding from her vagina.

2.18 Finally, the Paediatric Consultant recorded a third version of events; that mother was downstairs and has heard Molly cry out. She found Molly with blood on her hands. In this version, her partner was out at the shops at the time of the incident. Although the Consultant paediatrician had the referring information from the hospital she did not have the original account given to the GP.

2.19 From these differing accounts, it is impossible to establish whether mother's partner was part of the nappy changing event, or even in the house at the time. It would also seem that none of the adults were aware of the possible injury caused by the sandal until Molly mentioned it to the paediatrician at the PFN.

2.20 Further tests were undertaken, including swabs for STI's which were all negative.

2.21 The doctor then contacted Children's Social Care to inform them that she had seen Molly and on balance, she felt that this was probably an accidental injury caused by Molly falling on her sandal. Social Care requested that Molly be admitted overnight as it was not entirely clear what had happened. The initial medical opinion was that this was disproportionately cautious given the presentation of a happy child with a likely medical explanation for the injury. However Social Care had obtained some information from the Police regarding the history of sexual offending by mother's partner and took the view that they would prefer Molly to be admitted overnight to enable further assessments to be made.

2.22 The doctor discussed the information about her partner with Molly's mother, who acknowledged that she was aware of the allegations, but they were made by an ex-girlfriend and motivated by jealousy. Molly was transferred back to a local Hospital (this was to enable Molly's sibling to be brought to the hospital to be with mother) and admitted overnight with the agreement of Molly's Mother.

2.23 The doctor's findings were documented and written up the same evening and a follow up appointment booked for one week later. The following week Molly attended a review appointment on 6th May 2015 with the doctor in the Children and Young People's Clinic. Molly was observed to be a "chatty and confident little girl. She remembered the toys from the previous week and played appropriately for her age". Her injuries were seen to be healing satisfactorily.

2.24 The specialist nurse supporting the doctor liased with the allocated Social Worker and was informed that Molly's mother had suggested a further possible cause of the injury; a toy car with a broken and sharp edge. The social worker also provided further information regarding the extent of mother's partners sexual offending.

2.25 The Consultant Paediatrician's considered opinion was that, based on the available evidence the injury was on balance an accidental injury. However, the doctor included various caveats that "other causes of genital injury including abusive causes cannot be fully ruled out" and "further assessment is needed to understand the risks that mother's partner poses to the family and the degree of protection that mother can provide".

Practice Messages – Key Episode 2.

2.26 Molly had been seen by 4 different doctors in 3 different hospitals, from the initial appointment with the GP at 10 o'clock in the morning. She did not have her final medical examination until 9 o'clock that evening.

2.27 Each successive doctor was unaware of all the accounts given previously regarding the circumstances of how the injury had initially being identified. (the Consultant Paediatrician had the information from the referring Hospital but not the information from the GP.)

2.28 As a general observation, for a family dependent upon public transport or ambulance, the journeys between hospitals can add significantly to the delay in examining an injured child and potentially increase levels of stress for the child and her parent, although this was not an issue in this case.

2.29 The Consultant Paediatrician and Social Care Team Manager discussed their different perceptions of the risk posed to Molly and agreed a change of plan, which protected her overnight – this was good practice.

2.30 The conclusions of the Consultant Paediatrician who examined Molly were accepted as virtual "proof" that the injury sustained on 27th April was accidental. A close reading of the doctor's report shows that given the position of the injury, general presentation, and lack of discomfort the doctors' opinion was that on balance this was likely to be an accidental injury caused by falling on her sandal. However, the report also noted that the possibility of an abusive cause could not be fully ruled out, and would need to be re-visited in the light of further information.

2.31 This was another occasion where a face-to-face strategy discussion would have been extremely useful for all the professionals working with the family to share information, and most importantly the limits to the medical opinion that the injury was accidental.

KEY EPISODE 3 – S47 Assessment April 2015

2.32 The section 47 investigation[3] commenced on 28th April, the day mother and her two children returned home from hospital.

2.33 Important information was obtained through Northumbria Police regarding criminal behaviour by mother's partner in Scotland. While he had no previous convictions, there were 12 pending prosecutions, 3 of

[3] Under Section 47 of the Children Act 1989, if a child is taken into Police Protection, is the subject of an Emergency Protection Order or there are reasonable grounds to suspect that a child is suffering or is likely to suffer Significant Harm, a Section 47 Enquiry is initiated. This is to enable the local authority to decide whether they need to take any further action to safeguard and promote the child's welfare.

which were for rape of a person over the age of 16 and 1 rape, which was stated to be 'domestic related'. There was no information relating to offences against children. Because there was no reported history of offences against children and because the medical view was that the injury to Molly were most likely to be accidental, the police played no active part in the section 47 enquiry.[4]

2.34 As part of this investigation mother's partner was asked to leave the home while the enquiry was undertaken. A written working agreement was put in place to clarify the expectation that he would not reside in the family home and would not have unsupervised contact with the children for the duration of the enquiry. As an additional safeguarding measure the Social Worker arranged for unannounced visit to the family from the Children's Support Team and, out of hours, by the Emergency Duty Team.

2.35 Mother and partner agreed to these stipulations under duress and now stated that mother's partner had not been in the family home when the injury took place (this was different from the 2 earlier accounts which were given to the GP and Hospital).

2.36 The working agreement was subsequently modified to allow mother's partner to visit the home for 1 ½ hours each day, with the stipulation that his contact with the children was supervised by mother. Despite the family's reluctance all the evidence is that they complied with this agreement.

2.37 During the section 47 enquiry mother maintained that her partner was not present when the injury was caused and she believed it had been caused accidentally by Molly falling on either her sandal or a toy car.

2.38 The section 47 investigation raised concerns about Molly's school attendance and speech and language delay, although at 3 years old she was below statutory school age. There was limited information regarding Molly's health, but nothing that raised any concerns.

2.39 There was little background information obtained about Molly's mother, or her partner, and what was known was self-reported and not verified by contact with health agencies or Social Care in Scotland. Also, there was no attempt to contact Molly's birth father.

2.40 Both the Health Visitor and the GP had contact with the family during the time Children's Social Care were undertaking the section 47 investigation. The Health Visitor undertook a home visit on the 13th May as part of a monthly review of the family. The following day Molly was taken to the GP

[4] Section 47 enquiries are either "joint" involving the Police and Social Care or "single agency" and undertaken by Police or Social Care alone. The decision should be made through a strategy discussion and not decided unilaterally.

with a recurrence of the genital itching problem first recorded in July 2014. This visit had been prompted by the school who noticed Molly passing urine frequently and showing signs of discomfort.

2.41 During the section 47 enquiry all the presenting risk factors regarding parenting were addressed to some extent; the information from the Scottish Police concerning the allegations against mother's partner was that the offences were against adults, he was not on bail for the offences and further decisions about how the case against him would proceed would not be made until later in the year. School attendance issues were also addressed during the enquiry and significantly improved following a meeting between the school and parents in mid-May. The Consultant Paediatrician's opinion was that the injury to Molly was most likely accidental and there were no other health or other concerns which challenged this view.

2.42 The conclusion of the section 47 enquiry was that there was insufficient evidence to initiate a child protection conference, but the case would remain open and a more comprehensive child and family assessment would be undertaken within the recommended 45 days.

2.43 The extended assessment period also provided a rationale for remaining involved with the family after mother's partner had been allowed back in the home. He returned to the family on 8th June and the case remained open until 22nd July as no further concerns had emerged at this time. The fact that Molly's mother, and the maternal grandmother were fully aware of her partner's criminal history was considered an additional safety factor and would make them more alert to risky situations in the future.

2.44 The conclusions of the assessment were based on direct observation, interviews with the parents and maternal grandmother and limited input from School and the Health Visitor. The observations of parenting by social work staff (including out of hours and unannounced visits) were positive and seemed to show a warm and loving relationship. The parents consistently denied any problems or difficulties either in their relationship or with parenting their children.

2.45 A further unresolved event occurred on 20th July 2015 when Molly's maternal grandmother rang the surgery for an urgent appointment. She described Molly as curled up in pain and screaming (which the receptionist could hear). As there were no appointments available, she was advised to dial 999 or take the child to A&E, she agreed to do the latter. However, there is no record that Molly was seen by any doctor, or taken to Hospital following this incident.

Practice messages Key Episode 3

2.46 The decision to undertake further assessments following the conclusion of the section 47 enquiry was taken because both the social worker and team manager were uneasy and did not feel they properly understood what was happening in the family.

2.47 While further exploration of the issues within the family was an appropriate response to the concerns raised but not addressed by the section 47 enquiry, again it would have been useful to convene a multi-agency strategy meeting to share perceptions and pool knowledge of the family at this point.

2.48 The workers involved have acknowledged that intuitively they felt that they did not have a full picture of what was happening in the family. This underlines the importance of background and historical information in providing a context for current behaviour and have the knowledge to be able to challenge and probe parental patterns of behaviour where necessary. The failure to obtain this important history meant that the assessment could not be fully completed.

2.49 It would seem that the GP who saw Molly in mid-May was not aware the previous history of genital rashes. Although the discharge letter from the Hospital had already been received regarding the genital injury, there is no evidence the GP saw it. and if so, whether sexual abuse was considered a possible cause of her symptoms. It should also be noted that this was a different GP from the one who had seen Molly in 2014.

KEY EPISODE 4 - Liaison between Police Scotland and Northumbria Police April 2015

2nd occasion – 28th April 2015

2.50 As part of the section 47 enquiry Northumbria Police contacted Police Scotland in the early hours of the 28th April for information regarding Molly's parents. Within 2 ½ hours Police Scotland were able to provide two intelligence reports regarding sexual offences in Scotland (the attached reports concerned mother's partners offending against his previous partner and did not contain any information on his history of sexual offending and specifically no involvement of a child or concerns about any child). However, the email went on to state that: "as there are no safeguarding issues" further information would need to be requested during office hours from the relevant area. The email gave a named Officer, fully conversant with mother's partners offending, who could be contacted. However no further contact was made by Northumbria Police to follow up this information.

2.51 The failure to identify the offence history as a "safeguarding issue" is puzzling, but Northumbria Police were not reliant on Police Scotland to inform them of mother's partners offending; a PNC (Police National Computer) check revealed that he had 12 pending prosecutions, including 2 alleged rapes of females over the age of 16 and one other count of rape. The email exchanges 9 months earlier also detailed his offending history including risks to children.

KEY EPISODE 5 - 2nd Referral to Children's Social Care 9th December 2015. Allegation of Child Sexual Abuse

2.52 A second referral was made to the Social Care Emergency Duty Team by the Police on 9th December 2015. They had arrested mother's partner in relation to grooming allegations involving a 14-year-old female. He was released on bail the same day and the decision was subsequently made by the Crown Prosecution Service not to charge.[5] A Child Concern Notification (CCN) was sent from Northumbria Police to Children's Social Care, but this did not initially identify mother's partner as living in a home with children. This important link was made by the Social Workers receiving the CCN.

2.53 Northumbria Police were contacted on 10th December by mother after her partner had arrived at the home address, as he had no conditions on his bail he believed he was entitled to live there. Given he was on bail for grooming offences Molly's mother was concerned whether the children would be safe around him. At this point, Molly's mother decided to move the children to their grandmother's address. The Police advised mother's partner to leave the family home and made a referral to Children's Social Care.

2.54 Molly's mother and grandmother gave an undertaking that Molly and her sibling would remain at the grandparent's home and that her partner would have no contact with the children.

2.55 Social Care began a second section 47 enquiry and visited the family on the 11th December 2015 and found that Molly's mother had moved the family to their grandparents home due to her fear of her partner. Molly's step grandfather informed Social Care that Molly was afraid of her mother's partner and became distressed in his presence. He described that she was fearful and would cower and scream when her mother's partner came into the room. Maternal grandmother also reported that

[5] The CPS would have charged Mother's Partner with this offence as the evidential threshold was met. However, in view of his substantial custodial sentence any subsequent trial was deemed not be in the public interest as this would not affect his current sentence.

Molly was sore in her genital area, and recently had an infection that could have been thrush and was always complaining of stomach pains.

2.56 It had been agreed that this section 47 enquiry would be a joint investigation by police and social workers. A Strategy Meeting was held and Molly had her second forensic medical on 11th December. Molly was spoken to, and she disclosed that she had been sexually abused by her mother's partner.

2.57 Molly and her sibling remained in the care of her mother and grandparents for a while and subsequently moved to live with foster carers and both were made the subject of Care Orders.

3. ANALYSIS

3.1 Safeguarding Molly was a complex multiagency task, and within the practice described in this review there are some examples of decisive, analytical, and child-centred multiagency practice.

3.2 However, close examination of the details of the case also show that sometimes the lack of collaboration and exchange of information led to prolonging the time Molly was at risk from her abuser and delayed its final discovery. It is ironic that mother's partner's arrest for a crime he did not commit led to the discovery of his abuse of Molly. Despite her grandparents alleged concerns, they had not shared these with any agency, and thus Molly may have continued to be at risk.

3.3 It should be noted that domestic abuse had not featured in the assessments by any agency of the relationship between Molly's mother and her partner, quite the opposite in fact; as the family were seen to have a loving and warm relationship. Also, no information had been provided in the routine screening questions that had been asked by the Health Visitor or Midwife. Therefore, the extent to which her partner could exercise coercive control over Molly's mother and apparently convince her that previous allegations of sexual assault were the invention of a jealous ex-partner was not explored.

3.4 The lack of assessment and focus on Molly's mother's partner would seem to be a further example of the lack of assessment of significant males in families; where the workers became over-reliant on Molly's mother for information about her partner.[6] It was known that his previous relationships have been violent, yet Molly's mother was rarely seen without him and there were few opportunities to talk to her alone about their relationship.

[6] A lack of assessment of significant males is a recurrent them in Serious Case Reviews. See for example: Hidden men: learning from case reviews and New learning from serious case reviews: a two year report for 2009 - 2011

The full extent of his previous offending was not known to professionals in Northumberland at the time because of the problems in obtaining information from Scotland

3.5 This case is also notable in respect of the Social Worker's reluctance and unease in terminating their involvement at the conclusion of the section 47 investigation in April 2015. In the face of some convincing arguments that the injury was explicable and probably accidental and lacking any hard information about concerns about the adults, the Social Worker nonetheless felt that the risks in the family were not properly understood.

3.6 A more comprehensive child and family assessment was commenced, but unfortunately ran out of steam, partly because of the difficulty in obtaining historic information from the GP and Police Scotland. The lack of a multiagency meeting compounded the isolation of the Social Worker and an opportunity was lost to consider the findings of the Social Work investigation alongside information from the school, GP, and Health Visitor.

3.7 It would have been helpful to produce a Child in Need plan, which would have formed the framework for multiagency meetings and facilitated exchanges of information between professionals (but not all professionals as it wouldn't have included police in the same way a strategy meeting or Child Protection conference would have). While some agencies believed that Molly was a 'child in need', it would have been easy to verify whether this was the case; the fact that no meetings were held to review the plan clearly demonstrated that no such plan was in place.

4. EMERGING THEMES

Failure to consider child sexual abuse

4.1 Following Molly's visit to the GP in April 2015 due to the unexplained genital bleed, the possibility of sexual abuse was not recorded by any doctor until the paediatric forensic examination by the last of 4 doctors who saw her that day.

4.2 There are no records to indicate that the GP considered sexual abuse as part of a differential diagnosis, although the available guidance[7] would have advised him to do so, and equally importantly, accurately record those concerns. If the GP had been considering the possibility of sexual abuse the correct course of action would be to notify Children's Social Care.

[7] Protecting children and young people. The responsibilities of all doctors p13

Lack of a Strategy Discussion and Initial Child Protection Case Conference

4.3 During the events which unfolded on the night of 27th April 2015, there was little time for anything that could be considered a strategy discussion. However, the case did raise some difficult questions which would have benefited from face-to-face collaboration and challenge between the relevant agencies. Other than providing information from Police Scotland, Northumbria Police had no further involvement in this case, although as an agency they were in possession of relevant information concerning the potential risk posed by mother's partner in the light of his previous offending history.

4.4 The decision that this section 47 enquiry should be a single agency was contrary to the multiagency guidance[8] for investigating alleged sexual abuse. The decision appears to have been made primarily by the police, based on the partial information they had received from Police Scotland about mother's partners offending history. The possibility that he may pose a risk to children does not seem to be actively considered or discussed between agencies.

4.5 It is clear from the paediatric assessment of the injury to Molly, that the doctor's opinion was that, on the balance of probability it was caused accidentally. However, the Paediatrician was not aware of the changes to the story of how the injury was caused, nor the offending history of mother's partner. This information may have affected the doctor's conclusion regarding the cause of the injury.

4.6 Finally, the intuition of the social worker and team manager responsible for the section 47 enquiry was that, despite the conclusion of the medical examination, they did not fully understand the scenario of how Molly was injured and they were uneasy in accepting that it had been caused accidentally.

4.7 Paradoxically, the lack of hard facts seems to have inhibited the process of seeking a multiagency discussion. The criteria for convening an initial child protection conference are twofold; firstly, that child protection concerns are substantiated, and secondly that the child continues to be at risk of significant harm. Based on these criteria it is clear that Molly did not reach the threshold, which is why children Social Care took the decision to undertake a further child and family assessment. However, the lack of a multiagency discussion at this stage may represent something of a missed opportunity to test professional opinions, and seek further information.

[8] Northumberland LSCB Procedures Manual - Section 47 Enquiries section 7

4.8 A further issue concerns the recording of the investigation process. Northumbria Police have no record that they participated in any strategy discussion. However, because of the limitations of the Social Care recording system, the contact between the agencies was recorded as if a strategy discussion had taken place. This was not an attempt to deceive, but there is a clear risk in a recording system which does not accurately reflect what has happened.

Communication between Police Forces

4.9 The exchanges between Police Scotland and Northumbria Police were key in the perception of risk posed by mother's partner. Information was sought on 2 distinct occasions; in June 2014 when Police Scotland requested the assistance of Northumbria Police in locating mother's partner, and subsequently assisting with his arrest. The second occasion occurred in April 2015 when Northumbria Police requested background information on mother's partner from Police Scotland.

4.10 The first exchange involved contact between a Detective Constable in Scotland and a neighbourhood Police Inspector in Northumbria in June 2014. The purpose of this contact was to ascertain the correct address for mother's partner to enable him to be interviewed as part of the investigation into alleged sexual offences. Once it had been confirmed that he was living in the area, the Detective Constable in Scotland gave brief details of mother's partners alleged sexual offences.

4.11 The Inspector from Northumbria Police immediately queried whether they should be concerned about his presence in the area, and specifically asked whether mother's partner should be considered a risk to children. While the response from the Detective Constable in Scotland, does not specifically answer this question, he provides sufficient detail of the alleged offences (which include allegations of child sexual abuse) to raise concerns about the risk mother's partner posed towards children.

4.12 Crucially, this information was not shared with the Police Constable sent to visit the address; he was only informed that Police Scotland were investigating an allegation made by a former girlfriend of mother's partner. This limited remit was inadvertently confirmed by Molly's mother, who stated she was aware of the allegations and believed they were made by his ex-partner to cause trouble.

4.13 Further emails were exchanged to arrange support for the arrest interview, and transport of mother's partner back to Scotland to be formally charged on 13th June 2014. However, Police Scotland did not subsequently inform Northumbria Police that mother's partner had been released on bail without any conditions or further monitoring. The Police Scotland policy is to inform victims when a suspect is released, because

Molly's mother had not made a complaint, she was not considered a victim and therefore there was no procedure in place for informing Northumbria Police, or any other agency in England of the decision.

4.14 The second exchange of emails occurred on 27th April as part of the section 47 enquiry with a request for information from Northumbria Police to Police Scotland. By the time the request was made, the Police had logged that Molly had been examined by the Paediatrician and there was a plausible explanation for her injury. Police Scotland received the request just after midnight. Due to it being received outside of the usual office hours the Police Scotland response only contained limited details of 2 intelligence reports concerning mother's partner's sexual offending in Scotland, which only referred to his offending against an ex-partner. The full extent of his offending, including allegations made relating to children does not seem to have been available to the respondent from Police Scotland at that time. Clear details were provided of the relevant Officer who could provide further information regarding mother's partners offending history and the status of any ongoing investigation, however, these were not followed up by Northumbria Police.

4.15 It would have been helpful if the outcome of mother's partners Court appearances in Scotland had been reported back to Northumbria Police. At this point, there was still active communication between the two Police Forces; in fact, the Detective Constable in Scotland thanked his English colleagues for their help on the same day mother's partner was released by the court without any bail conditions. The actions of Police Scotland suggest that they did not consider mother's partner, despite his offending history to be a risk towards children. This resulted in a 10-month period; between June 2014 and April 2015 when Northumbria Police were unaware that mother's partner was residing in the area on bail and facing charges for sexual offences.

Assessment

4.16 If there is a common theme in the assessments undertaken regarding Molly, it is that they have tended to focus on presenting issues without sufficient consideration of historical information.

4.17 The child and family assessment undertaken by Children's Social Care following the section 47 enquiry in April 2015 did not obtain information from Social Care in Scotland. It would have been good practice to contact Molly's natural father, and to obtain information regarding her mother's current partner's previous offending history. The assessment was also thwarted by the lack of information from the GP surgery who did not respond to requests for information.

4.18 However, it is to the credit of the Social Worker and Team Manager involved that they kept the case open in an attempt to complete the assessment and build a working relationship with the family. At the time. Molly's mother, maintained that her partner was not in the home when the injury occurred (in contradiction to the story given at the time of the incident) and it was therefore unfair of Social Care to insist that her partner live elsewhere.

4.19 The passage of time tends to play a part in the assessment of risk; by the time the case was closed there appeared to be a tacit acceptance of the following "facts":

a) mother's partner was not at home at the time of the injury,
b) that the cause of the injury was accidental was accepted by all agencies,
c) there were no indications of any problems in the relationship between the adults,
d) the family were believed to be compliant in keeping to the working agreement,
e) family were working positively in some areas and there had been a significant improvement in Molly's school attendance.

4.20 The family appeared to be stable and the quality of the relationship and home conditions were thought to be good. For Social Care to insist that mother's partner remained outside of the home, would have seemed contrary to the evidence of their assessment.

4.21 Northumberland LSCB has produced useful guidance on undertaking assessments[9] which would have been a useful checklist and guide for a complex assessment. In addition, the NSPCC guide: Ten pitfalls and how to avoid them[10] provides a research based critique of mistakes commonly made in assessments.

Lack of risk assessment regarding sexual offending

4.22 There does not appear to ever have been an assessment of mother's partner in relation to his sexual offending as an adolescent. Undue emphasis and inappropriate reassurance was placed on his known history of sexual offending against adults - the fact that he was not known to have recent child victims should not have been interpreted as him posing no risk to children. The assessment of risk appears to have been primarily focused on the criminal definitions of his offending to the extent he was only considered a risk if he had been convicted of an offence.

[9] Single Assessment Framework - Pre-birth to 18 years
[10] Ten pitfalls and how to avoid them. NSPCC 2010

4.23 It is widely accepted that to rely on conviction rates as an indicator of the extent of a person's offending, or the seriousness of the risk they pose, would lead to a significant underestimation of potential risk.

4.24 In assessing the risk Molly's mother's partner posed undue emphasis was placed on his offences being against older females. This conclusion is not supported by the research into sexual offending; equal, if not more, emphasis could have been placed on the relationship between an abuser (particularly relevant given his history of sexually harmful behaviour), and victim and the opportunity posed by living as part of a family with a child.

4.25 The child and family assessment undertaken by Children's Social Care did not successfully seek out historical information regarding his previous offending history. The available background information would have supplied information about previous attempts to work with the family by Social Services and details of sexual abuse.

4.26 However, Northumberland Children's Social Care did try in vain to get clarity about his offending history from Police Scotland; several attempts were made to get information from different sources but at no point did any of the available information suggest he had been accused of offences against children.

Significance of wider family

4.27 Molly's maternal grandmother played an important role in Molly's childhood. She was clearly an important support for Molly and played a significant role in supporting Molly's mother, both emotionally and practically. More importantly, she offered refuge and respite to Molly and her sibling when Molly became frightened of her mother's partner.

4.28 While she may have been perceived as a protective factor. It is also the case that she did not report Molly's apparent, fearful reaction against her abuser to the Police or Children's Social Care. It is possible to imagine that she had divided loyalties between her daughter and granddaughter, but in the light of the previous concerns there is no doubt that she had a responsibility to report these appropriately.

Professional curiosity.

4.29 The authors of the independent management reports (IMR'S) commissioned for this review were asked to note, specific evidence of professional curiosity shown by their staff when engaging with this family. Without exception, all agencies could identify where this was

demonstrated, but they were also able to recognise that its use was inconsistent and on some occasions, it was notably absent.

4.30 It is important therefore to establish a shared definition of professional curiosity and it meaning across a multiagency audience. Expectations of competence in this area vary between agencies; one expects the Police, with their training in investigation to be more practiced than other professionals. However, this review demonstrates that it is equally important for GP's, Social Worker's and Health Visitors to have skills in challenging and probing information.

4.31 The Munro Review of Child Protection recognised that professional curiosity needs to be embedded in the practice mindset of those working with families and is, in part, how a worker exercises the "respectful uncertainty" advocated by Lord Laming following his review into the death of Victoria Climbie in the 1980s.

4.32 "Respectful Uncertainty" is generally recognised to mean the process of corroborating and validating information provided by a service user to establish that it is truthful and has been correctly understood. Laming was directing his comments specifically as Social Workers, but the principle applies equally to other professions:

> "The concept of "respectful uncertainty" should lie at the heart of the relationship between the social worker and the family. It does not require social workers constantly to interrogate their clients, but it does involve the critical evaluation of information that they are given. People who abuse their children are unlikely to inform social workers of the fact. For this reason at least, social workers must keep an open mind."[11]

4.33 The need to develop skills in professional curiosity has arisen alongside an increased awareness of issues such as disguised compliance where cooperation is superficial and follows the line of least resistance, but without a meaningful engagement. Consequently, the desired change is not achieved, and seemingly cooperative parents continue to place their children at risk.

4.34 Professional curiosity may describe the tenor of the relationship with service user, but to develop the necessary skills and develop an open and questioning mindset, workers need regular effective supervision to test out the strength of their assessments and highly developed interpersonal skills to challenge families and other service users in a way which does not lead to a breakdown in the working relationship with a family.

[11] The Victoria Climbie Inquiry p205

4.35 Very few LSCB's provide separate training on the topic of "professional curiosity"[12], for most LSCB's however, it would be more effective to include it in the context of other multi-agency child protection training. This also give the opportunity for its importance to be reinforced on different training courses. It should also form part of training offered to supervisors by their respective agency.

5. EXAMPLES OF POSITIVE PRACTICE

5.1 As part of the process of completing their Individual Management Reports (IMR's) agencies were asked to identify examples of good practice as well as areas for improvement. Inevitably Reviews will concentrate on organisational, systemic, and individual failings. However, this should not deny the opportunity to also learn from examples of practice that was competent, sensitive and based on sound professional judgement.

a) The discussion between Consultant Paediatrician and Social Care Team Manager out of hours on 27th of April 2015. This was an example of professionals being able to challenge decisions, share information and agree a different course of action to promote effective safeguarding.

b) The Health Visitors practice of offering "listening visits"; recognising Molly's mothers' vulnerability particularly in relation to domestic abuse and offering practical advice and support about how to report concerns to the Police and details of local support groups.

c) The Social workers' and Team Managers' professional judgement leading to the decision to keep the case open following the section 47 enquiry. The Social Worker made tenacious efforts to obtain background information about offending. Although the efforts did not produce results at the time, the effort and creativity put into this should be recognised.

d) Written agreements were well used to manage the case and underpin a safety plan. They were clear and explicit about the safeguarding concerns and expectations. The family did not agree about the need for restrictions on contact but they did appear to be compliant. The Children's Support Team were used appropriately to monitor the family circumstances and ensure that mother's partner was not spending time in the family home when he was not supposed to. In terms of

[12] Brighton and Hove LSCB and Wakefield and District LSCB are two Boards which provide information on professional curiosity.

effective practice. It is important to note that proactive and regular social work visits reinforced the written agreements.

e) The quality of the out of hours' response - despite being reliant on staff working full-time during the day. Information was obtained, analysed, and subsequently used to raise concerns about the cause of the injury and garner agreement for keeping Molly in Hospital overnight. There is no evidence to suggest that the safeguarding and protection of Molly was adversely effected by the incident occurring out of hours.

f) The identification of Mother's partner from the grooming allegation and linking him with the family where there were vulnerable children. It should be recognised that it was the individual action of the allocated worker which made the connection between the person named in the grooming investigation as Molly's mother's partner. Although the link would have been made eventually, this realisation allowed steps to be taken to safeguard Molly and her sibling immediately.

6. RECOMMENDATIONS

Recommendations arising from the review.

1. Strategy Meetings/discussions should always be held in cases of suspected Child Sexual Abuse and recorded as such.

2. Face to face multi-agency strategy meetings should be held in complex cases[13]. Northumberland LSCB should review local multi-agency threshold guidance to ensure that it provides adequate guidance regarding strategy meetings.

3. Northumberland Children's Social Care should seek to improve the quality of its assessments in three specific areas:
   a) They must ensure that Assessments of families where children are at risk should consider historical information about the background of parents and carers. Wherever possible, this information should be corroborated and self-reported information should be treated with a degree of caution.

   b) Assessments of individuals with a history of domestic abuse should always consider the possibility that the current relationship may also become abusive. Assessments should also consider that an abusive relationship need not be overtly violent; and may also include coercive control and intimidation.

   c) Adults who pose a risk to children may require additional or forensic assessment, however from the evidence of this review it is important that social care staff have sufficient information to challenge unsafe assumptions about the level of risk based on previous offending.

4. All agencies should accept that while the key responsibility for obtaining and analysing this information rests with Social Care, they also have a key responsibility in supporting the assessment process by providing information, specialist knowledge, explanation, and interpretation where necessary.

5. Northumberland LSCB should seek assurance from constituent agencies that the constraints of their recording systems do not inhibit information sharing or lead to inaccurate records.

[13] It is accepted that there is no overarching definition of what constitutes a complex case; the term is differently used to denote complex health needs, organised abuse, and cases where there are different perceptions between professionals. However, an argument can be made for providing a framework and leaving it to professional judgement, in this case, for example, the complexity arose from the difficulty in constructively engaging the family and difficulty in obtaining information.

6. Northumberland LSCB should brief all GP practices on the specific learning from this review; that they should consider the possibility of sexual abuse in all cases where there is a genital injury.

7. All agencies should review their participation and engagement in strategy meetings to ensure:
   a) decisions about single/joint agency investigations should be made following consultation with Social Care
   b) there are effective systems to ensure that there is full and comprehensive sharing of information

8. Northumberland LSCB should seek assurance form Northumbria Police that the issues raised regarding their processes for recording and sharing information have been independently investigated and the lessons learned shared within the force area.

9. Northumberland LSCB should review its training provision to ensure that "professional curiosity" is adequately addressed in multi-agency training.

10. Northumberland LSCB should review its current Child Sexual Abuse training provision to ensure that it considers recent learning and research.

11. Northumberland LSCB should review its inter-agency guidance on Child Sexual Abuse to ensure easily accessible advice is available regarding the recognition of abuse and recording and reporting requirements.

APPENDIX 1

TERMS OF REFERENCE

Molly Terms of Reference.doc