NORTHUMBERLAND SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

OLIVIA

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1. INTRODUCTION

Background

1.1 In 2016, Northumberland Safeguarding Children Board commissioned a Serious Case Review into a case of child sexual abuse (Molly). The overview report was completed in February 2017 and included several findings regarding the investigation of intra-familial child sexual abuse.

1.2 Olivia's case came to the attention of the board while the review of Molly was nearing completion, it was quickly apparent that there were many significant parallels between the two cases.

1.3 The Board decided on a review, which would fully consider the circumstances of Olivia's abuse but would also consider the learning from the Molly Case and identify recurring themes and the lessons about how intra-familial child sexual abuse is investigated and responded to.

Introduction to the Serious Case Review

1.4 This case concerns the sexual abuse of Olivia, who was 12 years old when the first incident of sexual abuse by her mother's male partner became known. The initial disclosure was for sexual touching. An initial child protection investigation proved to be inconclusive and there was no corroborative evidence to support the allegation made by Olivia.

1.5 Four months later Olivia made another disclosure to her grandmother that there had been further incidents of sexual abuse by mother's partner. These allegations included being asked to watch pornography, mutual sexual touching, and penetration.

1.6 The case therefore raises serious issues regarding the investigation of child sexual abuse, the assessment of risk, the management of risky adults within the community and how children are "heard" and protected when they make a disclosure.

The Decision-Making Process

1.7 Northumberland Safeguarding Children Board considered the circumstances of Olivia's case and concluded that it met the criteria for Serious Case Review. However, it also recognised that a Serious Case Review concerning a similar case had recently been concluded, which had examined many of the same issues, which were applicable in Olivia's case.

1.8 The fundamental difference between the two cases was that Molly was very young when she was abused and not able to articulate what happened, whereas Olivia was clear with the descriptions of her abuse, but the lack of corroborative evidence led to a delay and further abuse before she was effectively protected.

THE PROCESS

Terms of Reference

1.9 In view of the similarities between Olivia's case and another recent SCR (Molly). The independent chair of Northumberland Safeguarding Children Board decided on this occasion to undertake a review, which focused on the similar themes, which emerge from both cases and consider whether there were systemic and organisational issues which effected the safeguarding of children who were the victims of intra-familial sexual abuse.

1.10 All the agencies involved with the family contributed written summaries outlining their contact with family members with notes about any specific issues, including examples of good practice. These reports were analysed by a multiagency safeguarding panel, which assisted in the completion of this Overview Report.

1.11 This approach was agreed by the National Panel of Experts and OFSTED as an efficient and cost-effective way of ensuring that the circumstances of the case were given thorough consideration, and avoided some of the inevitable repetition in reviewing two very similar cases which came to the Board's attention at the same time.

2 ENGAGEMENT WITH THE FAMILY

2.0 Olivia's mother supported by Olivia's grandfather met with the chair of the Serious Case Review Committee 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. Olivia's Mothers views will be shared throughout this report. The final version presented to the Northumberland Safeguarding Children Board will be made available to her prior to publication.

3 BACKGROUND INFORMATION

3.1 Olivia is the eldest of 5 children; she has 2 younger brothers and 2 younger half siblings who are the children of her mother's partner – the man who abused her.

3.2 Olivia has a mild physical disability making her more at risk of falling and tripping. When Olivia was 2 years old a brain injury was diagnosed which impaired the development of motor skills and impacted on her learning ability. Whilst in the early stages of her primary years the gap between her and her peers was marginal, and she was felt to be progressing with some support in school, that gap widened as she went through Primary and onto Secondary school.

3.3 Her parents separated when Olivia was 3 years old. There was a history of domestic abuse towards Olivia's mother, and evidence that the children had witnessed drunken arguments and aggression between the parents. The split was acrimonious and over the year's serious arguments about contact to the children ensued.

3.4 The court defined contact as unsupervised, but that it must be held in a public place. Soon after these arrangements, commenced Olivia made her first disclosure of sexual abuse against her father during contact when she was 5 years old in 2009. It was alleged that her father had hurt her bottom during contact and her younger brother had also been sexually touched. A Section 47 Enquiry[1] was undertaken; Olivia gave a clear disclosure that she had been hurt, but there was no clear medical evidence for the allegation of sexual abuse, Olivia's father maintained that the allegation was maliciously motivated by his ex-wife to prevent his contact with his children. Children's Social Care provided ongoing support through a Child in Need Plan.

3.5 A year later in 2010 Olivia made a further allegation, physical assault by her father, alleging that he had punched her the in the chest during contact, her mother also reported that she had found bruises on Olivia's arm after she had returned from contact with her father. A further Section 47 enquiry was undertaken; the paediatric examination could not ascertain the cause for the bruising, although they were consistent with Olivia's disclosure. An Achieving Best Evidence (ABE) interview was undertaken and Olivia gave a clear account of being punched on the chest. However, due to a lack of witnesses or corroborating evidence, no further action was taken

3.6 In 2012, Olivia disclosed to a physiotherapist some of the abuse she had suffered at the hands of her father. She told the physiotherapist that he used to shout at her, hit her, throw balls at her head, let her drink beer, and gave her baby brother beer in his bottle. She also said that her father had touched her inappropriately. Olivia mentioned to the physiotherapist

[1] Under Section 47 of the Children Act 1989 an enquiry is initiated if there are reasonable grounds to suspect a child is at significant harm. A social worker usually conducts Section 47 Enquiries jointly with the Police,

that she was going to speak about these sad things with the counselling service at school.

3.7 This disclosure was managed and shared appropriately, including a discussion with Olivia's mother. She was aware that Olivia had started to talk about these issues and had encouraged her to only discuss them with trusted adults and not her friends. Mother recognised that the behaviour of her ex-partner had a significant impact on both Olivia and herself; she explained that the experience had made her overprotective. Mother also told the physiotherapist, she was in a new relationship and had introduced her new partner to Olivia around 6 months ago (in mid-2011). Mother stated that her new partner did not live with them, and there were no plans for this to happen, but Olivia got on well with him.

3.8 On several occasions in 2012 Olivia disclosed specific details of her abuse by her father to two different staff members at school. School were also concerned about Olivia's younger brother, who had started to show inappropriate touching behaviour towards other children in his class. The second referral in May 2012 prompted initial assessments on Olivia and her siblings by Childrens Social Care; these concluded that there was no ongoing role for Children's Social Care and the case was closed.

3.9 In 2013, Olivia made her first disclosure about abuse from her mother's new partner to her counsellor at school. She described how he swore at her, picked her up by the scruff of the neck and threw her on the bed and held her down. Olivia cried as she told the counsellor, "he will hurt me more if I tell, I'm frightened. He will turn into bad dad". Olivia also said that she had told her mother, but she did not believe her.

3.10 An initial assessment was completed; Olivia's mother was surprised by the allegation and believed that Olivia was not telling the truth. Mother's opinion was that Olivia was jealous that she was pregnant, and after her experiences with her father, she did not like men. Olivia did not repeat a disclosure to the Social Worker and appeared confused when talking about past events. However, mother agreed to ensure that her partner was not left alone with the children. Her partner completely denied the allegation and felt that Olivia had been influenced by extended family who did not approve of the relationship. There was no further action from Children's Social Care at this time.

Summary of Background Information

3.11 The early life experience of Olivia and her siblings had included a significant amount of traumatic abuse before she had reached 10 years of age. This included the ending of her parent's relationship due in part to drinks, drugs, and violence between them. Inevitably, there was an

element of emotional abuse for all the children as a result of witnessing the arguments and violence between their parents. The disrupted contact arrangements and insecurity in her relationships with her parents, particularly her father, were also likely to be a source of trauma and distress.[2]

3.12 On two occasions Olivia was the subject of Section 47 enquiries which included video interviews and paediatric examination following her disclosures of abuse. Neither occasion resulted in any proactive protective action being taken; in the case of her father, contact stopped when he no longer wanted it, and in the case of mother's partner, the disclosure was rationalised away as jealousy with an undertaking by her mother that she would protect Olivia. Olivia's mother commented in her discussion that Olivia's health needs were assessed by the regional specialist 'forensic' service following disclosures of sexual abuse. Mother reported whilst the circumstances requiring her to be seen were terrible, the service itself was very good and centred around Olivia.

3.13 Olivia also had a level of disability which was in itself an additional risk factor because it increased her vulnerability to abuse[3] and may have affected her ability to protect herself and disclose her abuse. Her level of disability may have been more significant than was first apparent.

4. INCIDENTS LEADING TO THIS REVIEW

Disclosure of sexual abuse – May 2015

4.1 In May 2015, Olivia's mother, contacted Children's Social Care advising that Olivia disclosed incidents of sexual assault by her partner. The allegations involved him washing Olivia in the bath, rubbing her in her genital area with his hand and a sponge, inappropriately touching her genital area to get her clean. Mother also informed Social Care that he had behaved in a similar way a year ago and she had told him not to do it again.

4.2 On the 13th of May 2015 a strategy discussion took place between the Police, Social Care, and a Forensic Paediatrician. It agreed that a Section 47 investigation should be undertaken. The medical report noted that Olivia was a vulnerable child and that the findings of the medical neither

[2] Children's Needs – Parenting Capacity. Child Abuse: Parental Mental Illness, learning disability, substance misuse, and domestic violence It is widely recognised that exposure to domestic abuse can constitute significant harm and have other negative impacts on children.

[3] Research studies indicate that disabled children are more likely to be abused than non-disabled peers, although the research evidence is mixed, and comparisons are not straight forward. see ''We have the right to be safe' Protecting Disabled Children from abuse NSPCC 2014

supported nor refuted the allegations; as digital penetration may occur without leaving any injuries, or injuries may have had time to heal.

4.3 An Achieving Best Evidence (ABE) interview was undertaken with Olivia and she gave a clear account of the sexually abusive behaviour from her mother's partner. The Section 47 report completed by the Social Worker concluded, "concerns were not substantiated" and recommended that a Children and Families Assessment was undertaken, leading to a Child in Need plan. There was no further action by Police following the ABE interview.

4.4 The decision not to convene an Initial Child Protection Case Conference seems to have been reached because the Social Worker highlighted that the incident had been reported by mother who appeared to be a protective factor, and was also influenced by the fact that mothers partner had moved out to his parent's address.

4.5 The advantage of calling an Initial Child Protection Conference would have been that information held by all the agencies could be shared, a full picture of the concerns provided and multiagency input and commitment to the plan, whether a Child Protection Plan or Child in Need plan, could be agreed.

4.6 Six days after the initial disclosure Olivia's mother contacted the Police to inform them that Olivia had become distressed over the weekend and told her that all the allegations were made up and were all lies. Police and Social Care visited Olivia at school to talk to her about this.

4.7 A formal strategy meeting took place in early June, which the Police were unable to attend, however they did provide a verbal update to the meeting. It is unclear if the final medical report of the forensic examination was available. This report very clearly outlined Olivia's account of her abuse, and potentially would have prompted a more assertive protection plan from Children's Social Care. However much of the information within the report had been given to the doctor by the Social Worker and Police attending the forensic examination and so both agencies should have been aware of this.

4.8 Olivia was referred for post abuse counselling. In Northumberland, this service is managed by Barnardo's who are commissioned by the Clinical Commissioning Group to provide a time limited (between 6 – 12 sessions) specialist counselling service. Olivia attended her first session towards the end of July, but work did not properly get under way before Olivia's second disclosure in September. The Project recommenced their involvement in January 2016 and ended their involvement after 12 sessions in May 2016.

4.9 The Social Worker advised mother that her partner should remain out of the home. The protection plan placed all the responsibility on her mother to keep Olivia safe with minimal supervision from any other professional. This was taking a great deal on trust. However, after several weeks, the Social Worker agreed that mother's partner could spend time at the home, as he was seeking contact with his own children. The Social Worker informed mother that her partner's contact with Olivia was to be in accordance with her child's wishes. The Social Worker met with the children to complete Signs of Safety work and meetings were undertaken with Olivia's mother and mother's partner to talk about safety during contact.

4.10 The worker advised mother that there should be no physical contact or any personal care of Olivia from her partner, equally the partner was correspondingly advised *'not be alone with the child as it would keep him safe from further malicious allegations'*.

Disclosure of sexual abuse – September 2015

4.11 In September 2015, Olivia made a further disclosure of sexual abuse by her mother's partner to her grandmother. The Section 47 investigation carried out established that Olivia was reporting further incidents of sexual abuse by mother's partner.

4.12 These allegations included being asked to watch pornography, touch his genital area, digital penetration, oral sex, anal penetration and being forced to masturbate herself and him.

4.13 During this Section 47 investigation a further forensic medical examination was undertaken. The examination was limited because of Olivia's age but no acute injuries were seen. It concluded that assault may have occurred without leaving any visible injuries or these may have healed. However, the report highlighted that this was the third medical Olivia had undergone as a result of disclosures of sexual abuse (including the previous investigation in May 2009 when allegations of sexual abuse against her birth father had been made).

4.14 A Police investigation began, and mother's partner was bailed after interview with conditions not to have contact with Olivia or the family.

4.15 The case went to Initial Child Protection Conference in October 2015 and Olivia made subject to a Child Protection Plan under the category of Sexual Abuse and Neglect; her siblings were also made subject to Child Protection Plans under the category of Neglect. The Child Protection Plan primarily involved maternal grandparents providing 24-hour supervision of the mother to ensure that her partner did not have any contact with the

children. Mother in her discussion stated she did not fully understand what was going on and felt threatened by and scared of the process. She believed that she was not always listened to and some factual information in assessments was inaccurate. Mother talked about lack of clarity regarding supervision arrangements and expectations around written agreements. She also commented on the high numbers of Social Workers they saw.

4.16 The case progressed into court following concerns about mother's ability to protect. A legal meeting was held at the end of September 2015 but there was a delay in issuing proceedings until January 2016.

4.17 In August 2016, the Court made findings of fact against mother's partner. The Court raised further concerns about the degree of protection provided by Children's Social Care. The court also raised concerns about the lack of clear and detailed written agreements around the expectations of mother in supervising and ensuring the safety of the children. In their discussion Mother and grandfather were able to reflect on what they felt was good practice. This included support by the Police throughout the whole criminal court proceedings including preparation for attending court, meeting the judge and on-going liaison during and after the trial itself. The family felt they were kept very well informed throughout and staff were sensitive to Olivia's needs.

4.18 The children have remained in the care of mother supervised by maternal grandparents, who also live at the home as a result of the Child Protection Plan.

4.19 All proceedings have now been concluded and a criminal trial resulted in the perpetrator received a 13 years' custodial sentence.

5. ANALYSIS

Disclosure Practice.

5.1 A disclosure of abuse to an appropriate person is a key point in beginning the process of protecting a child. In Olivia's case, there were numerous recorded attempts by her to tell a trusted adult what was happening to her. Therefore, it is worth reflecting on what we know of her experience and how the system responded to her.

5.2 On the first occasion when Olivia disclosed physical abuse at the hands of her father during contact, her mother was able to confirm the details and agreed that Olivia had been traumatised by these events. However, there was complete denial that her current partner could have acted in an abusive way towards Olivia. Mother's theory that Olivia was jealous of

her partner and unsettled by her pregnancy appears to have been accepted by the Social Worker allocated at the time.

5.3 The fact that Olivia did not repeat her disclosure to the Social Worker when interviewed is not an unusual response from an abused child. On this occasion the Social Worker spoke to Olivia in school at the end of the school day, and also spoke to her along with her brothers as she felt more comfortable with their support. Olivia's mother was informed of the allegation when she collected the children from school.

5.4 School clearly represented a safe place for Olivia; she had disclosed to different members of staff at school, furthermore, they were experienced in understanding her needs and her ability to communicate. The school made very clear records of her disclosure, however the Section 47 procedure requires the investigating Social Worker to seek their own corroboration of the allegation[4]. As this was not forthcoming on this occasion it resulted in a decision not to investigate further which delayed any effective protection of Olivia.

5.5 On the second occasion in May 2015, when Olivia described sexual touching by mother's partner, she again gave a clear disclosure of the type and nature of the abuse both during the ABE interview, and as part of the forensic medical examination. The abuse she described was unlikely to leave physical evidence to corroborate her story. Nonetheless, it remained consistent; with a similar level of detail in the accounts she gave to the paediatrician and the investigating Police officer.

5.6 The lack of forensic corroboration or witnesses led to a decision that there would be no further action regarding a criminal offence. However, this need not necessarily have meant that there was no further safeguarding action from anyone else. The fact that mother told that Olivia had retracted her allegation seems to have been accepted, with no consideration as to why this might be the case.

5.7 It may be significant that Olivia chose to make her first account of the last incident of abuse to her grandmother in early September 2015; the abuse occurred during the school holidays, which naturally prevented Olivia from speaking to anyone at school.

5.8 The final disclosure again showed consistency of detail across the accounts she gave to different professionals. Her account of the sexual abuse clearly describes in her own words the abuse committed against her. The nature of the acts meant that there was unlikely to be corroborating physical evidence, however, the description of the abuse is

[4] Northumberland Safeguarding Board Procedures 1.2.5 Section 47 Enquiries.

clear and graphic and almost impossible for a child who has not been subject to abuse to describe in this way.

5.9 On this occasion, the Section 47 investigation process functioned in accordance with the NSCB procedures; there was no delay in arranging the medical or conducting the ABE interviews. Olivia disclosed her abuse and gave consistent accounts of what happened to her. In the forensic reports, the paediatrician expanded on the meaning of 'neutral' or 'inconclusive' to explain that this could not exclude abuse.

5.10 However, the system did not seem to work well in two respects, firstly, the lack of a Child Protection Conference or follow up strategy meeting following the first incident meant that the clear disclosures of sexual abuse were not discussed with all the agencies working with the family, and the opportunity to consider the latest disclosure in the context of previous concerns was lost.

5.11 Secondly, there was also a delay in the final medical report being available to other agencies; the significance of this is that the clear and explicit language that Olivia had used to the Forensic Paediatrician failed to be communicated to those working with the family. Although Children's Social Care records demonstrate that Olivia had already told other professionals using this same explicit and clear language, there was an unassertive response, (which focussed on the needs of adults in the family, particularly mother's partner's desire to see this own children). This was a crucial time for Olivia who was unable to speak to trusted adults at school because of the holidays, and her mother was solely responsible for protecting her.

Linking Referrals

5.12 Linking referrals is a key aspect of child protection; there were concerning allegations of abuse during the relationship between Olivia's parents. This raises some concern about her mother's ability to protect and recognise boundary and safety issues. The development of a multi-agency chronology and appropriate parenting assessments in complex cases is crucial to ensure current behaviours and referral can be put in context of the family's history.

5.13 Mother's attempts to protect Olivia previously had been ineffective and therefore the decision to make her largely responsible for her daughter's safety following the later allegations was over optimistic and naive.

5.14 The practice of holding a face-to-face strategy discussion and being able to place new referrals in the context of historical information is a key function of these meetings. Relevant information in this case would

include; Olivia's previous abuse, exposure to domestic abuse, and mother's disbelief of Olivia's abuse and the importance of school as a safe place for Olivia to talk about what was happening at home.

5.15 At the same time as the school were hearing Olivia's disclosures of abuse they were also observing some worrying behaviour from Olivia's younger brother. The behaviour was indicative of stress and unhappiness and warranted further investigation about what was happening at home.

Medical Diagnosis

5.16 An overreliance on medical diagnosis to provide evidence of abuse led to a failure to recognise the seriousness of the assault and possibly lead to its effect on Olivia being underestimated.

5.17 In many cases, sexual abuse does not result in injuries and so the examination is normal. In Olivia's case, her account of the sexual abuse, both in May and in September was clear and explicit.

5.18 The term neutral was used twice in the reports on both occasions it was qualified stating that, "this was a neutral finding that neither supports nor refutes the allegations as penetration may occur without leaving any signs or injuries may have healed". Olivia was not physically injured or carrying any other evidence of the abuse on her person. However, her verbal descriptions were clear and consistent and contained specific details, which she would only know from direct experience.

5.19 The Paediatric reports following both examinations contain a verbatim account of Olivia's disclosure, which is good practice; this was shared following the examinations with the Police Officer present and the Social Worker. However, the delay in the written report becoming available meant that the detail given by Olivia to the doctor was not shared with other agencies. This may have reduced the full impact of Olivia's account although this same detail had already been shared with other professionals.

Social Work Practice

5.20 It should be noted that due to staffing issues and pressures of work, Olivia's case was dealt with by several different social workers. The ideal would be for the same experienced worker to be able to respond to Olivia's disclosures. This would have allowed a Social Worker to have prior knowledge of the child and hopefully to have had the opportunity to build a relationship with her.

5.21 In the case of the first disclosure the initial Section 47 investigation was undertaken by an agency worker and the case then transferred to a relatively inexperienced Social Worker. The significance of this is that to accompany a child through the investigation process allows a working relationship to develop. In addition, the worker has the opportunity to hear at first hand the full extent of the disclosure and can also assess parental attitudes.

5.22 The practice following the disclosure in May 2015 was weak and unassertive; parental assurances were taken at face value, as was Olivia's retraction of her disclosure. The perpetrator was even advised to avoid putting himself in situations where he may be subject to false allegations. It is not possible to know how this advice was interpreted by mother's partner, but one possible interpretation is that the Social Worker also accepted that the disclosure was untrue. Mother explained that she did not understand the process, which she claims was not explained to her and she felt threatened by the social work intervention.

5.23 There was no apparent consideration of the impact of all of this on Olivia herself; she remained in the care of her mother who had failed to protect her in the past, and in regular contact with her abuser. Apart from the trauma of the abuse, Olivia had to contend with the feelings of not being believed and the future consequences for her. Furthermore, the access to safe adults provided by the school was about to end for six weeks as the school holidays had started.

5.24 In the light of mother's disbelief of her daughter and inability to protect in the past, it was dangerously overoptimistic to believe that she could protect Olivia in the future. The Social Worker did not make any written agreement with the family, outlining her expectations of how Olivia was to be protected. Although the use of written contracts has been criticised in child protection practice, at least the existence of a contract would have provided an explicit statement of how Olivia was to be protected, who in the family would share that responsibility and any contingency plans if these arrangements broke down.

5.25 It is recognised that professionals are also "groomed" and are dependent on good supervision and peer support to obtain a reality check on their relationship with the family. There is little evidence of any professional curiosity in this case; particularly in cases of sexual abuse workers must remain vigilant and aware of falling into a collusive relationship with parents.

Assessment of Adults

5.26 The lack of assessment of adults, particularly men is a frequent and long-standing finding from Serious Case Reviews. In too many cases, the male

partner is only "known" through the perception of the child's mother. In Olivia's case, it was known and documented amongst all the agencies that the relationship with Olivia's father had been violent, unstable, and affected by the use of alcohol and drugs.

5.27 Mother's new partner, seemed to offer a different kind of relationship, although any lateral enquiry would have soon discovered that he also had a history of violent relationships and was not allowed to see his own children. Olivia's mother's insistence that jealousy motivated her daughters first allegations should have been examined more thoroughly. If Olivia was inventing stories of being abused, this should of itself raised concerns which warranted further assessment and additional support.

5.28 In the light of subsequent events a much more likely explanation is that mothers partner was grooming Olivia as a precursor to the abuse to follow; by demonstrating his power, threatening her with the consequences of disclosing and showing her that her mother would not believe her.

5.29 Two further aspects of focusing on the adults are relevant to mention at this point; firstly, the evidence of disguised compliance on the part of Olivia's mother and partner. They demonstrated a concern for Olivia's well-being, which was not followed through by their actions. Disguised compliance is particularly difficult to work with; and in this case, a relatively inexperienced Social Worker seems to have focused their efforts on building a relationship with the parents in the erroneous belief that they would offer protection. In reality, disguised compliance needs to be challenged by developing a sceptical view of apparent cooperation and checking up through a series of unannounced and, out of hour's visits.

5.30 A further aspect of the relationship between professional and parent is the rule of optimism. In this case, the historical information regarding mother's failure to protect was ignored in order to create a superficially positive working relationship between the adults. It was optimistic in the extreme to assume that Olivia's mother was capable of protecting her daughter. This is not to say that Olivia's mother was consciously colluding in the abuse of her daughter - the possibility remains, but it is not known - she may also have been to some extent "groomed" by her partner, and had emotionally invested in a fresh start with a new baby and new partner.

Post Abuse Support

5.31 This review should provide an opportunity for commissioners and providers of post abuse services to consider whether the current arrangements are able to meet the needs of children such as Olivia. She was referred twice

for short-term therapeutic work by a specialist service. It arose during the review that there is not a robust pathway in place for child victims of sexual abuse involving a range of providers to ensure children receive appropriate support both short and long term. This suggests that thresholds need to be re-examined to ensure that the right children are being referred and that the specialist service is one of a range of options, rather than the only option considered. There is a need for effective management and gatekeeping of specialist resources to ensure, firstly that the more serious cases are referred for specialist help, but also that children are not caught in a system where they are transferred between services because they fall between threshold criteria.

5.32 In this context, we should also consider the support offered to Olivia's mother, she had also attended a group work provision for non-abusing parents at the Project Olivia had been referred to. Given her history of siding with her daughter's abuser in the past, it is important to differentiate between her attendance and participation in the group with any meaningful shift in her attitudes around protecting her daughter.

Police Practice

5.33 A decision by the Police that they can take no further action because of the lack of corroborating evidence or other witnesses is not in itself unusual. However, the Police and other agencies need to be clear with all parties that the decision not to proceed with the criminal prosecution does not equate to them not believing the witness. In Olivia's case, her testimony was consistent, given in age-appropriate language and plausible. It would have been extremely helpful and supportive to Childrens Social Care if this message had been given in person at the follow-up strategy discussion and to the parents in the company of the Social Worker allocated to the case.

5.34 The shorthand of NFA (no further action) does not convey the subtlety of the thinking behind the decision-making, and the full explanation of the decision may have helped remind the allocated Social Worker and Olivia's mother that a potential risk remained. The lack of Police action may possibly have intensified the emotional pressure on Olivia to withdraw her allegation.

Children with a disability

5.35 Olivia suffered from mild cerebral palsy and had been subject to bullying in the past. As a lifelong condition, it may have made her more vulnerable to being abused because of her presentation and reported communication problems (although this does not seem to have affected her ability to disclose). Whilst in her early primary years, behavioural challenges were noted, there was improvement after parental separation with the ending of exposure to domestic violence and physical abuse.

The recurrence of those difficult behaviours should have led to consideration of whether Olivia was again being exposed to an unsafe situation. Her vocal opposition to contact could have led to a reassessment of its value, but where it had been insisted that contact continued, mother was in effect encouraged to override her daughters attempt to keep herself safe. This may have negatively impacted on mother's ability to listen and believe her daughter when further abuse occurred.

5.36 While there is no evidence that her disability affected how professionals perceived her credibility as a witness, it is widely recognized that children with a disability are more likely to be the victims of violence and abuse, and are less likely to give evidence in court.

The investigation of intra-familial child sexual abuse.

5.37 The investigation of intra-familial child sexual abuse is one of the most challenging areas of child protection practice. It requires practitioners of a high level of confidence and competence across three key agencies; children Social Care, Police family protection officers and forensically trained paediatricians.

5.38 Planning and effective information sharing is key to an effective investigation. Strategy discussions/meetings have often been an area of weakness in this type of Section 47 investigation. The fact that these meetings are called "strategy" meetings, rather than planning meetings or information sharing meetings, is indicative of a greater expectation on what such meetings will achieve. The "strategy" should encompass an understanding of the developmental abilities of the child, the history of previous concerns and investigations, a discussion of the current disclosure and the points to prove and an understanding of how the child is to be protected and any arrangements for formal feedback/wash up between the professionals (ideally a second strategy meeting or a decision to take the case to an initial Child Protection Conference).

5.39 In Olivia's case, some of the individual components of the Section 47 investigation seem to have been effectively and competently undertaken, however, the concluding information exchange and sharing of concerns does not seem to have taken place.

5.40 While protection systems usually remain dependent on a disclosure to trigger safeguarding action, Olivia's case illustrates that in the absence of witnesses or supporting forensic evidence, protection is much less certain. In Olivia's case, Children's Social Care appeared to wait for the 'finding of fact' in August 2016 to confirm information they had known all along.

6. LEARNING.

6.1 Intra-familial child sexual abuse is still likely to be the most common form of sexual abuse that professionals will encounter.[5] While most investigations will be triggered by a disclosure, all practitioners should be aware of the behavioural indicators of child sexual abuse and the importance of an accurate chronology.

6.2 Historical information and observations from others who know the child should be obtained to inform the investigation and to gain an understanding of a child's previous experiences.

6.3 The verbal disclosure by the child is one aspect of the investigation of sexual abuse.[6] The child may not disclose in an ABE interview, or have supporting forensic evidence. This may affect the action, which can be taken at that time, however, it should not negate the belief that the child may have been abused and still requires protection.

6.4 Practitioners should be aware of the possibility of disguised compliance and that as professionals; they also may be groomed or manipulated by abusive parents or those in denial about the existence of risk.

6.5 Children are most effectively protected when agencies work collaboratively, this means they have a shared knowledge of the child's and family's history and current situation and concerns are recorded and shared promptly. Correspondingly, when these safeguards are not available (due to school holidays, or missed appointments with therapists) professionals should increase the frequency of their contact with the child and family. It would be useful for all agencies to ensure the practice of recording "child not seen" or "child not brought" rather than did not attend.

6.6 Caution should be taken to ensure the meaning of terms such as 'neutral findings' or 'no further action' are clearly explained and understood by other professionals, i.e. that this do not mean that a child is not believed nor that there are no safeguarding concerns. Professionals may need to rehearse how they convey a clear message that concerns remain and particular care should be taken in explaining these meanings to children.

6.7 Although describing the results of medical examinations as "inconclusive" or "neutral" is technically correct; the literal meaning is that it is not

[5] Centre of expertise on child sexual abuse. Improving understanding of the scale in nature of child sexual abuse briefing. The most serious and repeated offenses are more likely to be committed by known persons, with family members being more common for girls and young women.

[6] No one noticed, no one heard: a study of disclosures of childhood abuse (NSPCC 2013) This report describes the childhood experiences of abuse of 60 young men and women and how they disclosed their abuse and sought help.

possible to reach an exact diagnosis or an inability to confirm or deny what was being tested for. In the context of sexual abuse, (particularly when written in a report and not explained) there is a risk that the absence of a definite finding could be taken as 'evidence' that alleged abuse did not occur.[7] Where reports are not available for early meetings, such as strategy meetings, paediatricians need to explain their findings and ensure they are understood. Other professionals need to consider how they use extracts from other professional reports within assessments and in reports for decision-making meetings.

6.8 Post-abuse services need to be flexible, and child-centred and able to work in a range of venues across the county. Therapeutic services should respond quickly to children post investigation, and seek to make early contact wherever possible. In the case of children who have been sexually abused it should be recognised that some children will need long term support and there needs to be a system in place for reviewing therapeutic need.

6.9 Supervision is an essential part of working with child sexual abuse; the nature of the work may emotionally affect practitioners. They will also require support in recognising disguised compliance and developing strategies to challenge this. Child sexual abuse cases also require management oversight to ensure that the multiagency network is functioning correctly; the child is being monitored, information exchanged and concerns passed on in a timely way.

6.10 It is possible that the recent national focus on specific forms of child sexual abuse such as child sexual exploitation, female genital mutilation, and forced marriage, has led to an over reliance on following process and procedure rather than focusing on the needs of children. There is currently no specific local guidance on best practice in investigating intra-familial child sexual abuse.

[7] The learning from several Serious Case Reviews is that the reluctance of doctors to explicitly attribute injuries to child abuse was interpreted as evidence that abuse had not taken place despite contextual information about families that would strongly suggest that it had. The important learning is that medical professionals should ensure their use of language is correctly understood, and correspondingly other professionals should question and challenge information they do not understand.

7. RECOMMENDATIONS.

It is clear given the similarities between the Molly SCR[8] and the circumstances of Olivia's abuse that many of the recommendations made in Molly's case are pertinent to Olivia's. Unfortunately, Olivia's abuse happened too soon after the recommendations from Molly's case were accepted to assess whether they had the desired impact on practice. Therefore, some of those recommendations are repeated here.

1. Face to face, multi-agency strategy meetings should be held in cases of suspected Child Sexual Abuse and chaired by an experienced children's Social Care team manager.
2. All agencies should review their participation and engagement in strategy meetings to ensure:
    I. all child sexual abuse investigations should be joint agency investigations between children's Social Care and the Police as a minimum.
    II. there are effective systems to ensure that there is full and comprehensive sharing of information
    III. where there has been a medical health assessment, Social Worker activity seeks the attendance of appropriate health professional or requests the findings of the assessment for presentation at the strategy meeting.
3. Northumberland Children's Social Care should seek to improve the quality of its assessments in four specific areas:
    I. 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.
    II. 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.
    III. 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

[8] The SCR on Molly is available on the NSCB website.

unsafe assumptions about the level of risk based on previous offending.

IV. Assessments must contain a multi-agency chronology and parenting assessment of main carers or partners.

4 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.

5 Northumberland Children's Social Care (CSC) should ensure that families are given the information required to understand any social work intervention. Staff must check out with the family and subsequently document they understand the process. CSC should also consider the development of leaflets to leave with families and children about their involvement, as families may need to reflect following any visit.

6 All agencies must ensure that listening to, and hearing what children say is important, particularly when they have been in unsafe or uncertain situations or they have learning or other disability, where their ability to express themselves is often compromised.

7 Northumberland Children Social Care should review the provision of supervised contact where parents and family members have been subjected to domestic abuse. If contact is believed to be in the child's interests, this needs careful consideration and review particularly where the child expresses reluctance.

8 Northumberland LSCB should review local multi-agency guidance to ensure that it provides adequate guidance regarding strategy meetings in cases of Child Sexual Abuse

9 Northumberland Children Social Care to review the frequency for supervision in relation to sexual abuse cases at both Child in Need and Section 47 investigations.

10 Northumberland LSCB should review its training provision to ensure communication of key messages in 3 specific areas:

I. Children and young people: recording related to disclosure, case recording and reports should include verbatim report of what the child said, including explicit and graphic language.

II. Perpetrators of sexual abuse:

a) Patterns of grooming behaviour, including moving between vulnerable families

b) Parents, carers and professionals may be groomed by plausible and engaging abusers

III. Practitioners: assessment of the non-abusing parent is key to effective risk assessment. The value and limitations of 'capacity to protect' assessments need to be fully understood

11 The provision of post-abuse support should be reviewed and a multi-agency pathway for referral agreed to ensure children receive the right support; this should include services provided by Barnados, CYPS (CAMHS), Primary Mental Health Workers and Early Help Hubs.