NORTHUMBERLAND SAFEGUARDING CHILDREN BOARD

Multi Agency Deep Dive Review Summary Report and Action plan

The 'P' Family

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.

Author: Margaret Tench Designated Nurse for Safeguarding Children

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Process:

This is a summary report taken from a multi- agency deep dive review using extensive multi-agency chronological information provided for Serious Case Review (SCR) Sub Group meetings of Northumberland Safeguarding Children Board (NSCB). Involvement with this family has spanned many years with early interventions from a neighbouring authority; however this report concentrates on involvement with Northumberland agencies once case transfer was accepted from the authority, November 2013, following a positive initial assessment.

The author is chairperson of the SCR Committee and although involved throughout the review process, has had no individual involvement with the family.

The summary report, emerging learning and subsequent action plan, will be available on NSCB's web site. The learning will be shared via multi-agency carousel events arranged early 2018.

Historic information:

The four children involved in this case were removed from their mother in the neighbouring authority due to physical and sexual abuse. In addition to this, one female child was systematically sexually abused by an adult neighbour of the family; this male later received a substantial prison sentence.

All four children were made subject of a Care Order October 2008. They had been placed with foster carers employed by an independent fostering agency in July 2006. The final care plan was for them to remain with the carers on a full Care Order. The carers were then successful (assessed by the neighbouring authority) in 2012 in seeking Special Guardianship Orders (SGO) for all four children.

The children first came to the attention of Northumberland County Council May 2013 but due to the case being the responsibility of a neighbouring authority, that authority dealt with the situation. The incident was following one of the male siblings disclosing physical assault by the male carer, no further action was taken at the time. The authority requested a case transfer November 2013 following an initial assessment in October 2013, Northumberland took the case over.

A strategy meeting was held early 2014 after a female sibling disclosed sexual abuse by one of her brothers. He was then subsequently placed in a Section 20 foster placement.

There then emerged a pattern of events where it was concluded that the carers did not recognise their own mental health issues or domestic abuse were impacting on the children, there were a number of allegations made regarding them involving physical abuse and they lacked the capacity to parent these vulnerable children. All four siblings were removed as a result of these concerns in 2015.

The judge in this case commented that a Serious Case Review should be considered, in light of longstanding concerns about the foster carers with an independent fostering agency, breakdown of placements involving other children placed with them in 2004, 2005 and allegations of abuse to one child from 2004-2008. Concerns also included assessment of the carers as Special Guardians by the neighbouring authority and the children returning home following the incidents in April and May 2013. Northumberland Safeguarding Children Board (NSCB) has agreed the period to be reviewed should be when the local authority accepted responsibility for the case from the neighbouring authority. The has been communication with the authority to outline this action and therefore any separate review regarding historical concerns raised by the judge, would be the responsibility of that authority and considered outside the remit of this report.

In relation to the comments made by the judge the NSCB identified that:

1. The long standing concerns regarding the family were raised with the neighbouring LSCB Case Review Committee, the Northumberland board manager and serious case review chairperson attended the neighbouring LSCB SCR sub-committee and explained Northumberland, having reviewed their involvement, agreed the case did not meet the criteria for SCR although an action plan had already been implemented as previously described. It was suggested that the neighbouring LSCB, given their responsibility for assessing the SGO carers and their relationship with independent fostering agency may be in the best position to identify learning from this case. This also included information sharing regarding previous concerns about children placed with the carers historically by independent fostering agency.
2. The incident where the children were returned in August 2014 was reviewed and the
   SCR sub-committee identified that all the relevant information sharing and strategy meetings were implemented correctly and identified good practice examples from this situation.
3. The work of the Police in this case is not yet concluded.

The NSCB identified that in relation to the children's/young person's involved undertaking a SCR may have a detrimental impact on the children's/young person's lives. Any SCR given the age of the children/young people would also seek their views. The majority of the children are currently placed in therapeutic settings and SCR enquiries may not be in the children's/young person's best interests due to the disruption this may have on their functioning, emotional well-being and mental health.

The Serious Case Review Sub Committee considered this case on two occasions, the second time using the Chronolator to develop a 190 page chronology of the case.

During the SCR sub committee's in-depth discussions, they found that whilst applying the Serious Case Review (SCR) criteria (Working Together 2015), they were not met. They found aspects of positive multi-agency practice that highlighted the case was managed in line with the LSCB, Local Authority procedures and demonstrated good information sharing.

The current situation and arrangements:

All of the children have been affected by historic abuse, some of which occurred prior to the care provided by the foster carers. This abuse has significantly impacted on the children's emotional health and well-being. All of the children are accommodated in alternative placements and are safe.

Emerging themes:

When the case was handed over to Northumberland, despite previous concerns, the foster carers had successfully applied for Special Guardianship (SG) and were assessed very positively by the neighbouring authority. They were described as 'exemplary' carers. The initial assessment undertaken by Northumberland prior to accepting the case identified no concerns, all of the children had been spoken to as part of the process and were very positive about their carers. They appeared settled, having lived with them for a number of years and opting to change their names to have the same surname as their SG parents.

One of the features of this case was the impact of the SG parents' behaviours in the way they were able to influence decision making. There was evidence of disguised compliance, manipulation and coercion of both professionals and the children in their care by both SG parents. They appeared to 'know the system' well. Despite this, there was evidence throughout of good multi-agency working and information sharing although risk assessments and decision making were based on what the children reported and concerns raised by the SG parents. They often described the problems stemming from the stresses dealing with difficult and challenging behaviour from the children rather than their poor parenting ability.

The children were visible and were spoken to in person regularly. Where assaults occurred, any injuries were appropriately assessed by a paediatrician. There were disclosures of physical abuse and subsequent vehement retractions and it was therefore very difficult for these to be progressed. The siblings on denying allegations, tended to blame the challenging and difficult behaviours on an older brother. One sibling has never made any disclosures regarding the SG parents and has always strongly denied any allegations her brothers made, again making it difficult for professionals to assess what had really happened. It later transpired during the court proceedings that the SG parents bribed them with gifts such as televisions for their bedrooms in order for them to change their stories and support them as their parents. Professionals at the time were completely unaware of this.

Learning:

There were a number of concerns about the carers even prior to the siblings being placed with them. It is not known how much the neighbouring authority was aware of these. It is important to ensure all information is actively pursued and obtained when receiving children transferred from another authority. In this case, there was no evidence to suggest this had not been done but considered good practice in general. Following this case, where it is known a carer has been provided by an independent agency, Northumberland local authority should ensure all relevant assessment documentation is obtained and reviewed.

When children disclose physical abuse, a medical assessment is usually required. This should be undertaken by a suitably qualified paediatrician and arranged by the social worker involved with the case. On occasions, even if the child's original explanation is accepted and injuries fit the history, should the child subsequently retract, it can be difficult for the paediatrician to unequivocally confirm non accidental injury, especially if the subsequent history is plausible. These type of findings can sometimes be referred to as 'neutral' and may often lead the police to be unable to take action on the basis of a crime taking place. It is really important to reinforce the paediatrician's assessment should only be part of a wider, holistic assessment. It is also really important for all agencies to understand the reasons why victims retract in these situations. These can include fear of further reprisals, being separated from family / carers and being moved to alternative care arrangements.

Parental mental health issues can have a major impact on children and young people. When this is combined with domestic violence, this is extremely concerning. In this case, there was an incident where the children witnessed domestic abuse between the parents which involved the male carer inflicting harm on himself using a knife. This must have been terrifying for the children. The professionals involved saw this incident as one of self-harm and focussed on parental mental well-being as opposed to a domestic abuse incident witnessed by the children. It is essential this is included in single and multi-agency training to ensure all staff are made aware of this.

This was a complex case and as such, had features commonly seen such as disguised compliance with carers who knew the system and were very manipulative. Whilst this is currently included in NSCB training, this needs to be reinforced and include the importance of robust supervision arrangements in cases such as this.

Recommendations:

1. NSCB - should seek assurances that when a case has been transferred from another authority, all reasonable efforts have been made to obtain all relevant information in order to make accurate risk assessments.

2. CSC **-** When carers have been employed by an independent fostering agency, assurances should be sought and documented regarding any previous concerns.

3. NSCB - to seek assurances regarding the emphasis placed on medical opinions to ensure these are part of a wider, holistic risk assessment as opposed to being seen as expert opinions in their own right, out-weighing other information.

4. NSCB - to seek assurances that all staff recognise and prioritise the impact on children of domestic violence in situations where other complex issues exist relating to parents / carers eg mental health issues, self-harm

5. NSCB to seek assurance that all agencies understand the reasons behind children who disclose abuse may often retract to ensure this information remains important in all risk assessments

6. NSCB should ensure relevant multi-agency training is reviewed to include robust supervision arrangements are in place with complex cases to identify issues such as disguised compliance and controlling, coercive and manipulative behaviours in carers.

Action plan: (See Appendix 1)

B Family case review – NSCB Action plan

Recommendation	Action required	Timescale	Lead officer	RAG rating	Evidence
1. NSCB - should seek assurances that when a case has been transferred from another authority, all reasonable efforts have been made to obtain all relevant information in order to make accurate risk assessments. *** NB this was not an issue in this case from a Northumberland perspective but SCRC agreed it would be good practice to test out**	(a)When a case is transferred from another authority, there should be evidence the North East Regional Transfer Protocol For CIN has been adhered to Case file audit to be undertaken	Sept 2017	AW / RHC		To be discussed and disseminated via managers' meeting Transfer process recirculated and on agenda for team managers meeting Oct 5th
	(b)All agencies to evidence appropriate information has been requested when a case transfers in to their area	Sept 2017	All		Feb 2017 email to all agencies to ask clarification of how transfers are managed March 2017 - Information received by NHCFT & primary care Sept 2017 - Discussed CRC, assurances received from Education

Recommendation	Action required	Timescale	Lead officer	RAG rating	Evidence
2. **CSC -** When carers have been employed by an independent fostering agency, assurances should be sought and documented regarding any previous concerns. Included in above case file audit.		Sept 2017	AW / RHC		Forwarded by AW to LS who has responsibility for family placements and incorporated in to procedures
3.**NSCB** - to seek assurances regarding the emphasis placed on medical opinions to ensure these are part of a wider, holistic risk assessment as opposed to being seen as expert opinions in their own right, out-weighing other information	The interpretation of medical opinions should be included in multi-agency training to ensure staff involved in assessments understand they are part of the wider analysis of a case, especially when findings are 'neutral'.	June 2017	AL		Email (Feb 2017) to committee chair to request learning from this case is discussed as an agenda item. Incorporated in to Section 47 training delivered by Designated Dr
4. **NSCB** - to seek assurances that all staff recognise and prioritise the impact on children of domestic violence in situations where other complex issues exist relating to parents / carers eg mental health issues, self-harm	Learning and Development Committee to review relevant single and multi-agency training to ensure the recognition of domestic violence and its impact on children is highlighted in all complex situations	June 2017	AL		AL invited to attend SCRC as a member. Attended 2.3.17, agreed to review and strengthen relevant training. All agencies to review their own single agency training Section 11 results

Recommendation	Action required	Timescale	Lead officer	RAG rating	Evidence
5. NSCB to seek assurance that all agencies understand the reasons behind children who disclose abuse may often retract to ensure this information remains important in all risk assessments	L&DC to include in all relevant multi-agency training and seek assurances from partner agencies regarding single agency training	June 2017	AL		AL invited to attend SCRC as a member. Attended 2.3.17, agreed to review and strengthen relevant training. All agencies to review their own single agency training
6. NSCB should ensure relevant multi-agency training is reviewed to include robust supervision arrangements are in place with complex cases to identify issues such as disguised compliance and controlling, coercive and manipulative behaviours in carers.	L&DC to include in all relevant multi-agency training and seek assurances from partner agencies regarding single agency training	November 2017	AL		