Safeguarding Children Partnership

Child Safeguarding Practice Review

Overview Report

Child Ab

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1. Introduction: Rational and Process of the Child Safeguarding Practice Review

1.1 On the recommendation of a Serious Case Review Panel, a decision was taken on 2 May 2017 by the Independent Chair of a Local Safeguarding Children Board (hereafter referred to as the Safeguarding Children Partnership) to commission a serious case review into the neglect and abuse of Child Ab. The recommendation was based on the decision that the serious harm suffered by Child Ab met the criteria for a Serious Case Review (hereafter referred to as a Child Safeguarding Practice Review) under Chapter 4 of Working Together 2015[1].

Purpose

1.2 Although the review was commissioned under Working Together, 2015, it is important to note that Working Together 2018 states that:

1.3 "*The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.*

1.4 *Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that purpose, including through employment law and disciplinary procedures, professional regulation and, in exceptional cases, criminal proceedings. These processes may be carried out alongside reviews or at a later stage…….*

Serious child safeguarding cases are those in which:

- *abuse or neglect of a child is known or suspected and*
- *the child has died or been seriously harmed"*[2]

1.5 For the purpose of transparency all Child Safeguarding Practice Reviews referred to the Department of Education are required to be published. This report takes account of the distress and harm which could be caused to Child Ab and siblings, as a result of the publication of this review. It is for this reason that care has been taken to ensure that this report provides only a brief summary of the circumstances which led to Child Ab (and siblings) being removed from the care of their mother and Stepfather, and concentrates on the key themes and learning arising from this case. All personal information concerning the family has therefore been anonymised.

Voice of the Child

1.6 Child Ab's behaviour was indicative of safeguarding concerns. The child's demeanour changed at school and it is questionable whether Child Ab had any friends or peers.

[1] Working Together to Safeguard Children 2018 replaced Serious Case Reviews with Child Safeguarding Practice reviews, Chapter 4.
[2] Working Together to Safeguard Children, 2018, Chapter 4, paragraphs 3, 4 & 10.

When Child Ab was encouraged to speak the responses were confusing and concerning.

Methodology

1.7 The methodology used for this review was a traditional model of requiring involved agencies to provide Internal Management Reviews (IMRs). A Practitioners Event was held on 8 August 2017, which 21 professionals attended.

1.8 A list of agencies who provided IMRs to the review, as well as a Panel of representatives from Partner agencies, can be found in Appendix 1.

2. Key Themes, Analysis of Practice and Lessons Learned

- **The Role and influence of adults in the household**

2.1.1 The arrival of Stepfather in the family home dramatically influenced the way in which Child Ab was cared for and how the child was treated by Mother and the other children.

2.1.2 It is evident from the information provided to the review that from the outset Child Ab was scapegoated by Stepfather. Child Ab was singled out for different treatment to that of the siblings.

2.1.3 Child Ab was the second oldest child in the family when Stepfather arrived. From the time he arrived in the family home, Stepfather dominated and controlled Mother and the children, but his behaviour towards Child Ab amounted to extreme cruelty.

2.1.4 The significant harm posed to children by violent stepfathers is a continuing theme of so many serious case reviews/child safeguarding practice reviews, as evidenced by high profile cases, such as that of Maria Colwell in 1973 and Baby Peter Connelly, thirty four years later, in 2007. Fortunately, in this case, Child Ab did not die. If Children's Social Care and Police had not acted when the school passed on the concerns arising from disclosures by Child Ab's siblings, then the outcome could have been very different. However, by not instigating child protection procedures when previous referrals had been made to Children's Services meant that Child Ab was left to endure continuing neglect and serious abuse for years.

2.1.5 The plausibility of Stepfather enabled him to take control of decisions concerning Child Ab's care and well-being, and that of the siblings. This is evidenced in the acceptance by professionals of:

- Stepfather's decision not to engage with various professionals;
- Not taking Child Ab to health appointments;
- Communication between the school and the family to be through Stepfather;
- Seeing the cause of Child Ab's behaviour to be the child's responsibility;
- An acceptance by professionals from all agencies of this adult male when Stepfather did not have parental responsibility for Child Ab or several of the siblings.

2.1.6 It is striking that throughout Stepfather's involvement with Mother, she was barely seen or communicated with by any professional agency. Given his controlling behaviour of the children, it seems more than probable that Stepfather also exercised control of Mother.

2.1.7 **Little is known of Stepfather's background. However, there was a lack of curiosity about his past, or challenge to his dominance, and the way he controlled the children, most especially Child Ab, Mother and professionals themselves. This is a lesson learned from this review.**

2.1.8 However, it is pertinent to remember, when considering the challenges presented to professionals by certain parents, Lord Laming's comment in his report on the Peter Connelly case:

> ***"****They [adults] become very clever at diverting attention away from what has happened to the child. Therefore, for people who work in this field – whether health visitors, police officers, social workers, whatever – have to recognise this in their evidence gathering. They have to be sceptical. They have to be streetwise; they have to be courageous."* Laming, 2009

- **The importance of clarifying parental responsibility**

2.2.1 As is the case with many reviews into the serious abuse or death of children, professionals often assume that an adult who presents with a child to an appointment/meeting, notably in respect of health appointments, is the parent. Challenge as to whether the adult has parental responsibility is rarely made. In this case, most agencies recorded Stepfather as 'father' of Child Ab and all the siblings, including those for whom he was not the biological father.

2.2.2 Stepfather took all the children to medical appointments, and in the case of Child Ab, decided whether the child would attend appointments or not and that the child would be home educated.

2.2.3 The importance of professionals ascertaining as to whether an adult presenting as the parent of a child, has parental responsibility, has been highlighted in this review. **The need for agencies to question and challenge whether an adult who states that they are the mother/father of a child does indeed have parental responsibility is a lesson learned from the review**.

- **The Child Protection Process**

2.3.1 It was not until Child Ab was removed from the family home by Police and Children's Services that child protection procedures were invoked when the child was police protected.

2.3.2 By seeking to explain Child Ab's presenting behaviour as being a problem with the child, meant that the dominating control of stepfather and the lack of intervention to protect Child Ab from abuse by Mother, was allowed to continue for many years.

2.3.3 When the decision was made that Child in Need plans were appropriate, the case was only open for a matter of three months, before it was decided that there were no concerns and it was appropriate to close the case. Within weeks of closing the case, Stepfather made professionals aware of his intention to electively Home Educate Child Ab. These decisions resulted in Child Ab not being seen by any professional, for over a year. In effect, child Ab was hidden from view and the abuse perpetrated by Stepfather, with a lack of protection by Mother, continued.

2.3.4 The need to undertake robust, comprehensive Social Care Assessments, in which the best interests of the child are paramount, is imperative if children are to be protected from harm and serious neglect. **Similarly, the necessity of not closing cases of Child in Need before ensuring that there is sufficient and appropriate monitoring of children in place, is a vital lesson learned from this review.**

- **Information Sharing**

2.4.1 **The need for information to be shared within and between agencies is the fundamental basis of good safeguarding practice and is a lesson learned from this review.** Whilst information was shared at professionals meetings, and for the brief period that the children were subject to Child in Need plans, the reliability of the information shared should have been questioned. The information provided to professionals was dependent on what Stepfather, and to a lesser extent Mother, chose to disclose.

2.4.2 There is a lack of information available to the review as to how many times professionals were able to gain access to the family home, whether the children were interviewed without Stepfather being present (it is known that Stepfather was frequently in meetings/consultations with Child Ab), and whether it was recognised that the voice of the child needed to be heard.

- **Disguised Compliance**

2.5.1 Throughout this review there is evidence of disguised compliance on the part of Mother and Stepfather. Mother abdicated her responsibilities and duties as a parent to Stepfather and it was his decision as to how and with whom the children could interact.

2.5.2 By attending meetings concerning Child Ab with professional agencies and seemingly engaging in processes, Stepfather maintained a façade of compliance and concern.

2.5.3 The reality was that Stepfather was controlling the engagement of professionals with Child Ab and siblings, and possibly with Mother.

2.5.4 **The importance of professionals to be confident to challenge parental non-engagement with agencies and to be alert to disguised compliance is a lesson learned from this review.**

- **Elective Home Education**

2.6.1 This review has highlighted the importance of appropriate monitoring of the increasing number of parents who elect to home educate their children. Child Ab was never subject to home education, as Stepfather failed to submit the application forms, which resulted in the child being out of school, effectively out of sight for a period of 14 months.

2.6.2 This was known by the education department, who persisted in trying to get the application forms, however, there are no statutory requirements for this to be submitted.

2.6.3 Whilst it is currently a parent's right to elect to home educate their child, the sanctions for not complying with the local authority requirement to visit the child's home,

interview the child, see the child's work and provide information concerning the programme of work produced by the child, are limited.

2.6.4 **Consideration of the national plans in regards to children who are home educated and the required resources to enable Elective Home Education to be effectively assessed and monitored is a lesson learned from this review and one which requires urgent attention if children are to be protected from the risk of significant harm**.

- **Recognising the significance of children not being brought to medical appointments**

2.7.1 Child Ab waited considerable time for an appointment to be assessed by CAMHS, only for Mother and Stepfather to fail to take the child to the appointment. They then failed to respond to contact the service when asked to re-book an appointment, resulting in Child Ab being removed from the list to be seen.

2.7.2 Similarly, Stepfather only took Child Ab to some of the other medical appointments.

2.7.3 Children rely on their parents and carers to take them to medical appointments. Thus, consideration of child protection concerns should be taken into account when children miss appointments because of non-engagement by parents with health services. **It is a lesson learned from this review that the consequences of children not being brought to medical appointments often results in the service being withdrawn and a child who is at risk not being seen.**

- **Police response to the joint home visit and subsequent investigation**

Whilst the removal of children from the care of their parents is difficult, any plans need to consider the safety and the best interest of children as well as the risk to children being left in an environment where the potential evidence for prosecution may be compromised; this is a lesson resulting from this review.

2 Conclusions

2.8.1 All Serious Case Reviews and Child Safeguarding Practice Reviews make for difficult reading. They also present challenges to professional practice. This review is no exception. The suffering, abuse and cruelty experienced by Child Ab was evidenced throughout the review. The manipulation and control exercised by Stepfather towards professionals with whom he came into contact cannot be underestimated.

2.8.2 The perseverance of the School Nurse in attempting to bring her concerns about Child Ab to the attention of fellow professionals is to be commended. Unfortunately, her referral to the MASH did not result in child protection procedures being instigated and it would be another year before action was taken to safeguard Child Ab and siblings.

2.8.3 This review has highlighted a number of key themes, the majority of which can be found in so many reviews into the death and serious abuse of children. It is hoped that the lessons arising from this review will lead to reflection on the part of the professionals involved in this case, and to those reading this report, as to how practice can be improved and strengthened to ensure that children such as Child Ab are prevented from exposure to such serious abuse and significant harm.

3 Recommendations

Recommendation 1: **All agencies to reinforce the requirement for professionals to maintain vigilance and professional curiosity when engaging with families where there are safeguarding concerns and a step-parent is present. This is to include:** **(a) Gathering as much information as possible about the stepparent to inform an assessment;** **(b) Seeking assurance and evidence that an adult purporting to be the parent of a child has parental responsibility to make decisions concerning the health, well-being and education of that child/children.**
Recommendation 2: **The Child Safeguarding Practice Review Panel are asked to consider the issue of Elective Home Education and hidden children, which is a national issue, with a view to undertaking a future thematic review.**
Recommendation 3: **On the basis that safeguarding of children must always be a priority, the potential risk on the evidence for prosecution needs to also be considered in the accommodation arrangements for children.**
Recommendation 4: **All agencies, especially those involved in health provision, to review their policies and procedures concerning children who are not brought to appointments to ensure that children are not placed at risk of significant harm by a service being withdrawn as a result of non-attendance.**
Recommendation 5: **The reading of this report should be mandatory for all professionals employed by partner agencies to ensure that the lessons highlighted in this report serve to improve and enhance safeguarding practice.**