Nottinghamshire
SAFEGUARDING
CHILDREN Board

Serious Case Review in respect of
CHILD 1, CHILD 2 AND CHILD 3

November 2013

Ruby Parry
Director of Consultancy
Reconstruct Ltd
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Introduction

1.1 This serious case review concerns sexual abuse, neglect, and physical abuse of three children over a period of many years. Several disclosures and allegations were made and the police investigated seven times, in 1997, 2000, 2001, 2002, 2006, 2007 and 2012. A conviction was not secured until 2013, when Mr and Mrs A were imprisoned for sixteen years and six years respectively. This sentence followed Mrs A being found guilty of child cruelty and sexual offences against child 1; Mr A was convicted of serious sexual offences including rape against child 1, child 2 and child 3.

1.2 The Sexual Offences Amendment Act 1992 forbids the publication of a name, address, or still or moving picture of the person during their lifetime if such publication is likely to lead to members of the public identifying that person as the victim of the offence. This report is therefore written in such a way as to remove any identifying information.

2 Purpose of the serious case review

2.1 The Nottinghamshire Safeguarding Children Board (NSCB) Standing Serious Case Review sub-group discussed the circumstances of the case on 20th March 2013.

2.2 The sub-group recommended that a serious case review should be undertaken on the basis that the circumstances met the criteria outlined in paragraph 8.11 of Chapter 8 of Working Together to Safeguard Children 2010, i.e.

“a child has sustained a potentially life threatening injury or serious and permanent impairment of physical and/or mental health and development through neglect or abuse’, and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.”

2.3 The Independent Chair of the NSCB accepted this recommendation and decided that the case should be subject to a serious case review and that the information regarding professional involvement with the children raised clear areas of concern about the way that they worked together to safeguard children.

3. Scope and terms of reference

3.1 The period to be covered by the review was 1st September 1997 to 30th June 2006, although professionals were asked to summarise any relevant information which fell outside of this timescale.

3.2 The terms of reference identified some key lines of enquiry to be covered by Individual Management Reports (IMRs) and addressed in the review itself. These
were identified in advance of the criminal proceedings and have formed the basis of the review and the learning. However, in order to meet the requirements of publication they are not reproduced in full here, but can be summarised as follows:

   How well agencies worked together to safeguard the children concerned in response to allegations and disclosures of sexual abuse and sexualised behaviour.
   Were procedures followed, and how well was policy and research used to inform assessment and practice?
   How well did agencies focus on the wishes and feelings of the children and listen to their voices?
   The circumstances under which Nottingham City Children’s Social Care (CSC) supported the making of an order placing child 3 with a family in which Mr A had access.
   Whether appropriate action was taken when it became apparent that plans were not being adhered to and the risk of harm was increasing.
   The impact of any racial, cultural, linguistic, faith or disability issues.

4. Methodology

4.1 Shortly following the decision to carry out this serious case review, the national Working Together guidance was updated in April 2013, and this increased the flexibility of the Board with respect to the approach to be taken to running the review. The new guidance is clear that serious case reviews are a part of the learning and improvement framework that the LSCB must have in place to identify learning from cases in order that local and national practice to safeguard children can continuously improve.

4.2 The review therefore must seek to:
   o identify precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
   o understand practice from the point of view of the individuals and organisations involved at the time rather than using hindsight;
   o be transparent about the way information is collected and analysed; and
   o make use of relevant research and case evidence to inform the findings.

4.3 The Serious Case Review sub-group established a panel to manage the review, and representatives from the key organisations were invited and asked to provide their agency chronology and to write an Individual Management Report (IMR) to address the issues outlined above. Reconstruct Ltd was commissioned to carry out the review, following a brief competitive tendering exercise.

4.4 Reconstruct is a private limited company which has been delivering training, consultancy, and direct services to children, including advocacy, independent visiting and participation services, since 1999. The company is committed to ensuring that the voices of children are not only heard, but listened to in a way that informs and improves the work of professionals in safeguarding children. The company has provided Ruby Parry as lead reviewer and Safron Rose as Panel Chair.
Ruby Parry is Director of Consultancy for Reconstruct and is a former Assistant Director of Children's Services, and Head of Children’s Social Care. She is a registered social worker with 33 years of experience and expertise in safeguarding and child protection, having written some of the first guidance in 1991 on the management of sexual abuse, including designing and delivering joint video interviewing training to the police and social workers. She has extensive experience in multi-agency working and in managing serious case and other reviews for the company over the last three years.

Safron Rose is a full time consultant and trainer for Reconstruct, and a former Director for the NSPCC. A qualified social worker and approved mental health social worker, she was a visiting lecturer on the Tavistock Centre post graduate Leadership Course (D66). Safron has over twenty five years’ experience of working with children and young people in different settings, including looked after children and those subject to child protection interventions.

4.5 The panel membership was as follows:

- Panel Chair – Safron Rose, Reconstruct Ltd.
- Lead Reviewer – Ruby Parry, Reconstruct Ltd.
- Service Director - Nottinghamshire Children’s Social Care, Nottinghamshire County Council
- Independent IMR Author - Nottinghamshire Children’s Social Care, Nottinghamshire County Council
- Service Director – Education Standards and Inclusion, Nottinghamshire County Council
- Independent IMR Author - Nottingham City and Nottinghamshire Education Services
- Service Director (Interim) - Nottingham City Children’s Social Care
- Independent IMR Author - Systemic Social Work Lead, Nottingham City Children’s Social Care
- Detective Chief Inspector - Nottinghamshire Police
- Independent IMR Author - Detective Inspector, Nottinghamshire Police
- Designated Nurse, Safeguarding Children - Nottinghamshire Clinical Commissioning Groups
- Group Manager, Safeguarding and Independent Review - Nottinghamshire County Council
- Nottinghamshire Safeguarding Children Board Business Manager - Nottinghamshire County Council
- Nottinghamshire Safeguarding Children Board Development Manager (Child Deaths) - Nottinghamshire County Council

Legal advice provided by:
- Senior Solicitor (Corporate & Environmental Law) - Nottinghamshire County Council

4.6 The way in which the review has been carried out is slightly different from previous reviews to reflect the requirements of the new guidance. In order to make the best use of time and to identify learning early on, it was agreed that professionals who were representing organisations were to be fully involved in identifying and
discussing practice lessons as they emerged, and in reflecting on the implications and learning for their organisations. To achieve this, those professionals were invited to a whole day session on 14th June 2013 to consider in detail the chronology of events and the story that underpinned those events. In addition to key panel members, the following professionals attended this meeting:

- Named Nurse Safeguarding Children - Nottingham City Care
- Specialist Practitioner Safeguarding - Nottinghamshire Healthcare Trust
- Named Doctor - Nottingham City Clinical Commissioning Groups
- Executive Lead for Safeguarding - Nottingham University Hospitals NHS Trust
- Named Nurse Safeguarding Children - Nottingham University Hospitals NHS Trust

4.7 The meeting identified some key hypotheses for further exploration in the IMRs and overview report and it was also clear that there were some agencies which had minimal involvement and therefore were not required to produce an IMR.

4.8 Those agencies which subsequently produced an IMR were:
- Nottingham City Council Children’s Social Care
- Nottinghamshire County Council Children’s Social Care
- Nottinghamshire Police
- Nottinghamshire Education

4.9 The other agencies were asked to produce a brief report to address two key questions:

- Did your agency’s contact with the child or young person result in effective help to them? If so how? If not, why not?
- What learning has there been for your agency, if any, and what will happen now as a result?

These reports were provided by:

- Sherwood Forest Hospitals NHS Foundation Trust
- Nottinghamshire County GPs
- Nottingham City Care Partnership NHS
- Nottinghamshire Health Care Trust

4.10 All of these reports, plus the integrated chronology which brings together the actions of all professionals, have formed the basis of this overview report, together with three panel discussions, research into what policy, procedures, practice guidance and research information was available at the time to inform the actions of those involved, and discussion with the NSCB Independent Chair on current Board priorities and publication issues. An early visit to one of the survivors also gave a clear focus to the review.

5. Confidentiality
5.1 Working Together to Safeguard Children 2013 clearly sets out a requirement for the publication in full of the overview report from Serious Case Reviews.

“All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB’s website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.”

5.2 The fact that the matter has been subject to criminal proceedings means that the identities of the victims are subject to protection under the Sexual Offences Amendment Act 1992 as outlined in the introduction to this report. This is intended to demonstrate respect for their human rights to privacy, sensitivity to their need to recover from the significant harm suffered in their childhood and to avoid placing in the public domain details which will cause them further distress.

5.3 The key message from the report must be about the experience of these children and young people and their contact with the professionals who are charged with protecting children, what those agencies have already learned and changed about their practice, and what they will now do as a result of understanding the lessons identified in this review.

5.4 Finally, the review has raised concerns about other children who were not the focus of this report. These issues formed an integral part of a picture which should have, and did at times, raise significant concerns for professionals, but did not at any point result in active investigation or protection of those other children. The need to ensure confidentiality limits the detail of this discussion, but these issues are inextricably linked in the review and I have therefore included in my analysis some research about abuse and disabled children which was available at the time of these events and which I recommend to the LSCB in my conclusions.

6. **Victim involvement in this review**

6.1 The female survivors were contacted at the start of the review to inform them about the review process. It is clear that they are in an emotionally and physically difficult place as they continue to struggle to deal with the impact of such long term abuse.

6.2 Child 2 agreed to meet with the lead reviewer and the LSCB Business Manager. This happened at her home on 10th July 2013. She wanted the review to address some very specific questions, and I have endeavoured to do so in my follow up meeting with her. Her broader comments have been incorporated into the report.

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1 Working Together to Safeguard Children 2013 p71
6.3 Whilst the adults connected with the children were notified of the review, they did not agree to be involved in the process or to comment on the terms of reference or findings.

7. Contextual information

7.1 The review concerns events that occurred up to fourteen years ago and many staff have left the organisations concerned, or cannot remember clearly what was happening at the time to inform their actions. Practice and legislation have also changed since that time, and the landscape of children’s services has continued to evolve, with the creation of the Director of Children’s Services role in the Children Act 2004 and the creation in many authorities of integrated children’s services, where children’s social care became part of a children and young people service, separate from the provision of adult social care.

7.2 The issue of child sexual abuse was highly reported in the press during the 1980s - 90s, but was subsequently overtaken by a media focus on child deaths, following the death of Victoria Climbié in 2001 and the publication of Lord Laming’s enquiry report in 2003, then the death of baby Peter Connolly in 2008. Sexual abuse has again become the focus of public and government attention in the last 18 months in relation to the Jimmy Saville investigation and the child sexual exploitation of young girls in Rochdale and Oxfordshire.

7.3 The professional knowledge base in relation to child sexual abuse was developing through the 1970s and 80s, and in Britain the Cleveland Enquiry Report\(^2\) into child sexual abuse published in 1988 highlighted the lack of coherent and consistent understanding and approach to the investigation and management of this issue. The Children Act 1989 then introduced sexual abuse as a recognised form of significant harm to children and heralded the development of clear joint procedures and policy between social care services, the police and health, although this continued to evolve over the next 10 years – and indeed continues to do so today.

7.4 In local government there have also been significant changes. Until 1998 there was one social care service covering all of Nottinghamshire but national local government re-organisation in 1998 created Nottingham City Council as a separate unitary authority. This means that records of agency involvement prior to 1998 are still held by the city services and those post 1998 onwards are held by the county council, as the children moved between these geographical catchment areas. Reference to City CSC prior to local government re-organisation in1998 relates to the City teams within the County CSC department.

7.5 Until the creation of a Children & Young People’s Services Department in 2008, social care services for children and adults in Nottinghamshire County were delivered by a single Social Care department.

7.6 The time lapse has also had an impact in that Nottingham City Council Children’s Social Care were unable to find all of the archived records, following the

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\(^2\) The Cleveland Inquiry Report Judge Elizabeth Butler-Schloss 1988
The transfer of all social care records onto an electronic social care record system. This included the files for child 2 and 3. Education records were incomplete and some had been destroyed as the subjects had reached 26 years of age. This means that it has not been possible to construct a coherent account of the education of the three subjects prior to the chronology period. This lack of information has seriously limited understanding of why certain decisions were made which in turn has had an impact on the ability to provide detailed analysis of the events and decision making.

7.7 The Memorandum of Good Practice in 1992 introduced the video recorded interview of child victims following on from the Criminal Justice Act 1991. This introduced the requirement for joint police and social service investigative interviews of child witnesses and there was a great deal of training and publicity around this, with funding being made available from central government to support the roll out of the video evidence programme.

7.8 This was adopted by police services as a way of obtaining best evidence from child victims. In Nottinghamshire there was likely to have been a transitional period around 1997 where video recorded interviews (VRIs) were being introduced but it is known that Nottinghamshire police were undertaking VRIs in 1998. When first introduced, these were undertaken with children under 14yrs of age for violent offences and under 17yrs for sexual offences.

7.9 In 1997 the structure of the police Child Abuse Investigation Unit in Nottinghamshire was different to the current day. The CAIU teams worked from two police stations. There was no dedicated referral unit, but officers were dedicated to the task of receiving incoming referrals.

7.10 The CAIU Referral Unit was set up around 2000 and is available between 8am and 4.30 pm each weekday. The terms of reference of the CAIU Referral Unit have evolved over time and the team are currently based within the Nottinghamshire County Multi-Agency Safeguarding Hub (MASH).

7.11 There have also been significant changes to the way in which police can make decisions in relation to criminal investigations. In 1997 the police were able to make decisions in relation to charging suspects with criminal offences or making no further action decisions. However, the practice at the time in Nottinghamshire was for the police to seek the advice of the CPS in child protection cases. These decisions are now made by the CPS in all such cases with no capacity for the police to make decisions about prosecution.

7.12 The Case Administration Tracking System (CATS) used by the police was developed by the CAIU and introduced around 2002. This enabled computerised records of child abuse investigations to be maintained. Prior to this date, all records were handwritten and have been subject to back record conversion. Some unused material may have been destroyed through the process of back record conversion.

7.13 In terms of children’s social care assessment practice, in 2000 the DoH ‘Assessment of Children in Need and their Families: Practice Guidance’ was published and social work practitioners would have started to implement it into their practice using it to assist their tasks of analysis, judgement and decision making.
Prior to this practitioners would have been using a local framework, based on the “orange book” – a guide to comprehensive assessment\(^3\). As above, they would also have had access to a range of research and training materials on the subject of sexual abuse, domestic violence and neglect, supporting the implementation of the Children Act 1989.

7.14 The author has had access to the multi-agency child protection procedures that were in effect prior to and after 2001, which reflect the national policy context at the time. This, plus a search of national policy and research available at the time of each of the allegations means that it is possible to make a judgement about what would have been considered to be good practice at the time and to analyse events within this context, rather than within what is currently in place. In this way the analysis seeks to avoid the trap of looking back with hindsight and therefore failing to understand what would have been reasonable for a child to expect in terms of agency intervention and understanding of the issues being raised and investigated at the time that they occurred.

8. **Subjects of the review**

All subjects in this overview report have been given anonymity as follows:

Name

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<tr>
<th>Subject</th>
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<td>Perpetrators</td>
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<td></td>
<td>Mr A</td>
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<td>Mrs A</td>
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There is no separate acknowledgement of the children’s parents as this would compromise the anonymity of the children.

9. **Summary of events and the allegations made by the children**

9.1 The integrated chronology of events is 121 pages long and there are many details which do not necessarily add to the understanding of what happened and who did what. Similarly the IMRs contain a lot of detailed narrative which has been incredibly helpful in understanding the perspectives of professionals. However, the Panel agreed that the focus would be on an analysis of key events, and in particular on the allegations and the professional response to these. Due to legal constraints, only a brief summary of significant events is included. The themes identified in the

\(^3\) Protecting Children: A Guide for Social Workers Undertaking Comprehensive Assessment, Department of Health 1988
events are then explored to try and identify why things happened in the way that they did.

9.2 By way of context, it is important to note that Mrs A was known to Children’s Social Care (CSC) since 1985 and the information held on her file should have indicated to professionals that she was a potential risk.

9.3 Mrs A married Mr A in 1997 and the couple remained known to the City area\(^4\) CSC although there was no intervention.

9.4 Child 1 and 2 were also known to City CSC prior to the period considered by the review through several referrals alleging neglect and emotional abuse of both children. These did not result in any protective intervention.

9.5 Disclosures and allegations of sexual abuse were made by the subject children on a number of occasions from 1997 until 2012: the police carried out seven investigations during this period but a conviction was not secured against Mr and Mrs A until 2013.

9.6 The first disclosure of sexual abuse was made by child 1 when she was interviewed by social workers in 1997; she was interviewed again the next day by two police detective constables. At the second interview the officers were concerned that there were inconsistencies in what they were told and that some incidents had not been mentioned the previous day. At the taking of the formal statement on the third day the social worker and the two police officers again noted inconsistencies and that child 1 was unable to go into detail and as a consequence the social worker formed the opinion that she was “fabricating” the allegations. Despite her allegations not being believed, child 1 never retracted them.

9.7 In 2000, child 2 disclosed to her teacher that she had been both sexually and physically abused by Mr A over a period of 5 years. The school made an appropriate and timely child protection referral to CSC who then took steps to protect child 2. However, this became a brief episode because child 2 withdrew her allegations and, it appears her retraction was accepted without question by CSC: there was no exploration with her about the reasons for this and, crucially, whether Mr and Mrs A were exerting influence over her.

9.8 Early in 2001 child 2 informed the school nurse she was pregnant by an unidentified older man: there is no evidence that this was investigated sufficiently. It does not seem to have been passed on to CSC or to the police; the only action that seems to have been taken was to confirm that she was not pregnant.

9.9 Two months later, child 2 repeated her allegations of abuse by Mr A at school and explained that she had been pressured to withdraw them previously: a

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\(^4\) Note that as at 7.4 until 1998 there was one Social Care Department covering the whole of Nottinghamshire and the separate arrangements for Nottingham City did not come into being until Local Government re-organisation in 1998. Reference prior to that date to City CSC therefore relates to the area now known as City, which would have been County at the time.
referral was made promptly to CSC. These allegations were clear but her situation did not appear to change as a result of this disclosure.

9.10 In May 2001, child 2 went to the police station where she accused Mr A of having sexually abused her and child 3: the Child Abuse Investigation Unit reacted promptly and appropriately, conducting a single agency interview on video (this was due to the fact that the Emergency Duty Team could not be contacted to obtain the services of a social worker for the interview). A medical examination was arranged as the allegations related to the previous night and it was therefore possible that there may have been forensic evidence to support the allegation. However, the medical was arranged for four days later and before it took place child 2 again retracted the allegation. There was no medical examination of child 3. As a result of these disclosures an Initial Child Protection Conference was convened in June 2001 and child protection plans were put in place.

9.11 In November 2001, whilst subject to a child protection plan, child 2 repeated the previous allegations made in May 2001 to a social worker: she did not retract the allegations on this occasion. She was reluctant to discuss the details and told her social worker that she did not want her to take any action. The subsequent review child protection conference de-registered the children in March 2002. None of the children were present at the conference or represented by anyone other than the social worker and their mother, who did not believe the allegations or act to protect her children from Mr A.

9.12 In April 2002, child 2 told a voluntary resource worker that she had been sexually abused by Mr A. It is recorded that she looked distressed, was uncommunicative and was in the company of an older ‘rough sleeper, referred to as a drug user. When a social worker visited the following day, child 2 refused to speak about recent events. The social worker and a family resource worker are recorded as having started to plan work with child 2 but she did not engage with the work. In July, a decision was made that child 2’s case would be closed: a subsequent visit to child 2 assessed her as being ‘safe and well’ with no presenting concerns and, following a case discussion with the team manager, it was decided to close the case as previously agreed.

9.13 In early October 2002 child 2 told a child advocate about the sexual abuse by Mr A over a number of years and said that she felt her concerns had been dismissed. The advocate made a further referral to County CSC. There was a delay of five weeks before any action was taken which no doubt reinforced any feelings that what she was saying was not being taken seriously. However, after the initial delay these allegations were responded to quickly in accordance with child protection procedures at the time. A child protection medical was conducted and found evidence consistent with sexual abuse. During her interviews, child 2 clearly stated her concerns for child 3.

9.14 On the same day, child 3’s school contacted CSC and referred to five instances of sexualised behaviour by her over the previous two months. A social worker visited child 3 but did not speak to her alone and no further action was taken in relation to investigating child 2’s concerns regarding child 3.
9.15 At this time, child 5 was also noted to be exhibiting behaviour that should have caused concern, but this was not followed up within the ongoing investigations.

9.16 Mr A was arrested and denied any sexual abuse of child 2, stating that she was attention seeking and fabricating her allegations. He was bailed by the police pending further enquiries.

9.17 Child 3 and 5 were made subject of child protection plans but Mr A continued to have contact with them in breach of that plan.

9.18 In February 2003 the CPS provided written advice to the police that they did not support a prosecution of Mr A. Although the account of child 2 was clear, the history of allegations and retractions was considered to undermine her credibility as a witness and it was their view that she would be ‘destroyed’ in cross examination. This decision had a huge impact on child 2.

9.19 Although nothing had changed in terms of the risks to the children, child 3 and child 5 were de-registered the following month as professionals felt unable to progress the child protection plans.

9.20 In 2006, an allegation of physical abuse of child 5 and further concerns about sexualised behaviour by child 3 were raised by a third party. There was a delay of over six weeks before that person was seen and interviewed and eight weeks before child 3 was seen. There was a further delay of a week before a strategy meeting was convened. However, once that was held and child 3 was seen, the responses were timely and appropriate and the children were properly safeguarded from any further abuse.

10. Analysis

10.1 How well did agencies work together to safeguard the children concerned in response to allegations and disclosures of sexual abuse and sexualised behaviour (see also 10.2)

10.1.1 The first allegations of sexual abuse were made by child 1 in 1997 and then by child 2 three years later. Neither were initially fully investigated nor believed by professionals. Analysis of the detailed chronology of events and the IMRs, shows that there is evidence of both good and poor practice in respect of risk assessment and joint working between 1997 and the allegations made in 2006. There is evidence to show that the wishes and feelings of the children were sought at various times during this period.

10.1.2 On a number of occasions both CSC departments failed to complete assessments within timescales or to fully engage other agencies in the process of multi-agency assessment. Similarly, procedures were not followed in relation to interviewing all of the children who were potentially affected when allegations were made. There is no evidence of there being a coherent and consistent approach to risk assessment and management which was informed by what the children were saying and doing.
10.1.3 The retraction of allegations was initially accepted without much question and no consideration was given to the reasons for these retractions, particularly around whether pressure was placed on the children to withdraw what they had said. Mr and Mrs A were able to manipulate the professionals involved and the assessments of the children too readily reflected the view of them projected by Mr and Mrs A. As a consequence child 1 and 2 were perceived at times as “troubled or difficult” individuals rather than children who had suffered significant harm. This consequently impacted upon the judgements made and actions taken in relation to the children and agencies failed to safeguard and promote the welfare of the children.

10.1.4 The emphasis in relation to investigating the allegations appears to have been on the obtaining of ‘hard evidence’ of sexual abuse – this term is used several times in the County CSC IMR. Without this evidence, the word of the children was judged either to be discredited, or to be insufficient to support protective action. This was also the case in relation to child 3 when she was displaying sexualised behaviour, observed by several different professionals. Whilst some protective action was taken at various times, this was never followed through: the lack of sufficient evidence to proceed with a criminal prosecution impacted on the judgements made and the action taken in terms of child protection processes, even though the burden of proof is different for the two processes.

10.1.5 Other factors, such as physical neglect and abuse at home were ignored and bruising was not followed up in respect of any of the children. Whilst there is a lack of description in the IMRs it is possible to infer that the children’s daily lives were very difficult, both physically and emotionally. It would have been reasonable to expect that a core assessment undertaken within the Framework for the Assessment of Children in Need and their Families would have highlighted some of this, regardless of the sexual abuse allegations. Why this did not happen is difficult to explain or to understand without the missing records, and the fact that the professionals involved are no longer available. However, it is clear from the records that even when protective action was taken, no professional other than social care escalated matters within their own agency or with partner agencies when plans were not complied with. In social care, escalation resulted in a great deal of discussion and in legal advice being taken, but this did not result in any positive change for the children.

10.1.6 It is also important to identify that at various points the children who made allegations were talked to by individual social workers and that efforts were made to obtain their wishes and feelings on those occasions. However, this did not happen for other potential victims and there are instances when social workers failed to raise issues of abuse or to question bruising. Social workers failed to ensure children were interviewed on their own. In this context it is highly unlikely that the children would have spoken up and it took a huge amount of bravery, and possibly desperation for them to do so when they did (see lessons learned for further discussion of this point).

5 City CSC IMR and Police IMR
6 The Framework for the Assessment of Children in Need and Their Families, DfES, 2000
10.1.7 The City CSC IMR also identifies that ‘interventions’ focused on the reasons for the initial enquiry but did not explore other issues that could have been significant indicators such as school absence. This lack of comprehensive assessment led to decisions being taken on the basis of an incomplete picture of the children and their circumstances and so the planning for them was flawed and failed to address the issues adequately.

10.1.8 Parental views were sought and there was a presumption that the children were being protected despite evidence to the contrary. Despite the efforts of some committed workers, the lack of effective intervention, failure to fully consider the experiences of the children on a day to day basis and abuse of the children continued until 2006.

10.2 How well did agencies focus on the wishes and feelings of the children and listen to their voices?

10.2.1 There is repeated evidence that the children were not always listened to and that they were more likely to be believed when they retracted allegations than when they made them. There is also evidence that the behaviour of child 3 as a toddler was not ‘listened to’ as being indicative of what she was experiencing, and opportunities for medical examinations which may have strengthened the children’s voices were not taken.

10.2.2 During the investigation of the first disclosure made by child 1 in 1997, the City CSC IMR notes that possibly too much weight was given to some things child 1 said that were later disproved. The fact that they were perceived to be of such significance suggests that there was a failure to appreciate the reactions of a young person when making a disclosure and being subjected to repeated questioning. Alternatively, it suggests that there was a failure to focus upon the important aspects of the disclosure and too much focus was given to the discrepancies in her account.

10.2.3 There is no record that child 1 was offered a medical examination to corroborate her allegations and to reassure her that she had not suffered any injury as a result of the abuse – or if she had, to treat it. The police IMR suggests that this may have been due to a third party stating that child 1 had an older boyfriend and that an examination would not therefore offer any convincing evidence. However, there was at this point no evidence that child 1 had been engaged in any sexual activity with her boyfriend.

10.2.4 Given the response from the professionals to the disclosure, it is hardly surprising that child 1 then “failed to engage and no further information was obtained in order to progress the statement” Police IMR.

10.2.5 Child 1 was accommodated by the local authority. She had three foster placements during the first ten days that she was looked after. It would be

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7Child protection medical assessments: why do we do them? Charlotte B. Kirk, Angela Lucas-Herald and Jacqueline Mok, Archives of Disease in Childhood (Vol.95, Iss.5) May 2010
reasonable to assume that such instability did not enable her to feel safe at that time. It is recorded that her placement was “unsettling” for other children in one family and she allegedly stole from another family. However, this behaviour was perceived by professionals as that of a dishonest and difficult teenager. With her allegations not being believed and her behaviour not being acknowledged as that of a child in distress, child 1’s voice was not being heard at this time.

10.2.6 Child 1 never retracted her allegations. With the situation effectively unresolved, CSC planned her return home even before the interviews had been concluded, an indication that a view about her may already have become fixed. Once home it would appear that almost three weeks passed before child 1 was contacted by a member of CSC (and then by telephone). Under these circumstances it is not surprising that after going missing from home several times, she appeared “more and more unwilling to work with the department” as was cited when the case was closed in April: again, her voice was not heard at this time.

10.2.7 The unwillingness of a child in need to work with the department is not, on its own, reason to close a case. The first response when meeting a persistent unwillingness to engage might more appropriately be to review the approach and perhaps reassess the needs. It is also of concern that the department appeared to condone an unacceptable level of risk for a child, given that her whereabouts were unknown. The police IMR also raises the question of a learning disability which would have further increased the vulnerability of child 1 to exploitation and may have affected her ability to cope with repeated interviews: however, this was not further assessed at that time.

10.2.8 Analysis of the circumstances surrounding the responses to allegations of sexual and physical abuse subsequently made by child 2 at school in 2000 is severely limited by the fact that the City CSC IMR author was unable to locate child 2’s file.

10.2.9 However, it would appear that staff at child 2’s school listened to her and then made an appropriate and timely child protection referral to County CSC in November 2000 when she alleged sexual and physical abuse from Mr A. County CSC then took steps to protect child 2, which suggests that they were following appropriate practice guidance and procedures at the time. However, the Police IMR notes that, “Ten days had elapsed between the original disclosure and the interview taking place … … There is evidence that the investigation was planned around the availability of professionals, rather than placing the needs of child 2 … first (sic)” Such a delay is likely to have raised doubts for child 2 and also to have given the adults involved an opportunity to put pressure on her, given that no protective measures had been put in place to support the child during this period. However, when child 2 retracted her allegations, there was no exploration with her about the reasons for this.

10.2.10 During this time, when sexual abuse had been alleged for a second time, there was no apparent comprehensive assessment of the children’s circumstances. Indeed, there is no evidence that the earlier, un-retracted allegations made by child 1 were reviewed at this time - had this been done, there may have been a consideration of the possible significance of injuries to child 2 at the time of
her retraction. As with the previous allegation it would appear no child protection medical examination was undertaken although one had been agreed “if necessary” (Police IMR). Instead, the case was closed.

10.2.11 CSC therefore appear to have moved to close the case with unseemly haste without any investigation or assessment. As with the case of child 1, it appears that CSC were more eager to believe that abuse had not taken place rather than to make a thorough assessment of risks and likelihood. It would have been more appropriate to have convened a child protection conference at which information could have been shared across agencies and an assessment of the reasons why these allegations had been made and then retracted could have been commissioned. Instead, the allegations seem to have had no impact on the actions of CSC and child 2 had no opportunity to discuss, in a safe place, what was really happening and the possible pressures on her not to talk about it.

10.2.12 When at the end of January 2001 child 2 informed the school nurse she was pregnant by an unidentified older man, there is no evidence that this was investigated sufficiently. It would be reasonable to have expected the school nurse and the GP to have been more curious about the circumstances of a child who thought she was pregnant, regardless of the history.

10.2.13 Child 2 repeated her allegations about Mr A at school in March 2001 and explained that she had been pressured to withdraw them previously: even if the retraction had not been doubted initially, there was now a case for reviewing previous actions. Unfortunately there is nothing in the County CSC IMR relating to this period due to the lack of records available to the author and so it is not possible to comment upon actions taken by CSC. There is also little recorded by child 2’s school following the initial referral, and no entries between the end of March and mid-May (Easter fell in the middle of April). However, given that child 2’s situation did not appear to change as a result of this disclosure, she was again not heard.

10.2.14 In May 2001, the opportunity for a medical examination of child 2 was lost once again after she attended the police station and alleged sexual abuse of both herself and child 3. Although an examination had been agreed, it was arranged for four days later and child 2 had retracted her allegations by then.

10.2.15 There was no medical examination arranged for child 3. As the police IMR points out: “Whilst there was no information to suggest that a medical examination of child 3 would have exposed evidence of sexual abuse, the previous allegations made by child 1 and child 2 should have raised the concern and consideration should have been given to the medical examination of child 3… …A decision to medically examine child 3 would have had to be carefully balanced with the likelihood or potential to find evidence of abuse. The author is of the view that this should have happened.”

10.2.16 Child protection procedures at the time stated that: “reasonable suspicion of significant harm to a young or otherwise vulnerable child will invariably
lead to a medical examination.\textsuperscript{8} It would seem that there was indeed cause for there to be ‘reasonable suspicion’ yet the procedures were not followed in this respect.

10.2.17 As a result of these disclosures child protection plans were put in place. During this period of registration, child 2 repeated her previous allegations to the social worker. However, there does not seem to have been sufficient emphasis on why child 2 was again raising this with a social worker now, and it did not result in any change for her. Her reluctance to discuss the allegations further is not unusual for victims of sexual abuse who will test out how their allegations are being received in order to decide what to do next and whether they can trust the person. It is hardly surprising in this case that child 2 then would not talk further given the previous failure of social workers either to convey any real belief about the abuse she was disclosing, or to protect her, but did this not absolve the worker from her duty of care to child 2.

10.2.18 Also, whilst it may have been difficult, but not impossible, to take action in respect of child 2 at this point, there were other children who may well, and in fact did, need protecting, yet her allegations do not seem to have resulted in any heightening of concern or change to the child protection plans and her voice remained unheard – see below.

10.2.19 After de-registration in March 2002, child 2 told a voluntary resource worker that she had been sexually abused by Mr A. History here was repeating itself as child 2 was left at risk of harm, and it is not surprising that when a social worker visited the next day child 2 refused to speak about recent events.

10.2.20 Again, child 2’s subsequent refusal to engage with work with professionals is not surprising. Child 2 had on occasions, but not always, retracted her allegations and she had confided, at least to one health professional, that pressure had been put upon her and she had been told what to say. Child 2’s refusal to work with County CSC is not clearly evidenced: she may not have been seen as co-operative but that may be because she was perceived as having behavioural and truanting difficulties – as she was described when referred by her social worker to a voluntary support programme – rather than as a victim of sexual abuse who was trapped in a powerless situation and unable to speak out. Closing the case under these circumstances would have given the impression that CSC found the situation acceptable and that child 2 was not believed or supported by professionals.

10.2.21 When child 2 later made a statement to a child advocate of sexual abuse by Mr A over a number of years, she stated that she felt that her concerns had been dismissed. The advocate made a further referral to County CSC. As stated in 9.13 above, the delay of five weeks before any action was taken, no doubt reinforced any feelings that what she was saying was not being taken seriously.

\textsuperscript{8} Inter-agency guidance on the Assessment of Children in Need, and the ACPCs Child Protection Procedures, Nottingham City and Nottinghamshire ACPCs 2001 Chapter 3, Section 5, p15
10.2.22 The decision not to pursue a prosecution of Mr A in February 2003 was a crucial blow to child 2. The police describe it as having a devastating effect and state that child 2 felt she had nowhere to turn. Although the police officers stated that they believed child 2, they did not seek to appeal this decision or to support child 2 to present her views to them. Child 2 would again have perceived this decision as a clear message that she was not believed.

10.3 Were procedures followed, and how well was policy and research used to inform assessment and practice?

10.3.1 As above, the case catalogues a great deal of poor practice which is characterised by a lack of understanding or application of what knowledge was available at the time about the dynamics and impact of sexual abuse. There are some examples of theoretical frameworks being used, but this does not seem to have been extended either to the discussions within children’s social care about the lack of ‘hard evidence’, or to the understanding about the manipulation of the children and of professionals by Mr and Mrs A and the vulnerability of child 3 and child 5 in the wake of child 2’s allegations.

10.3.2 Despite child protection plans not being adhered to, County CSC did not act and instead issued warnings which were not followed through. Furthermore, the assessments which were carried out did not fully reflect the children’s reality or wishes and so the premise for decision making was not properly informed.

10.3.3 In summary, there were examples of procedures being followed, of good inter-agency communication and working, and of the children’s wishes being ascertained, but there were also examples where this did not happen, and there was a lack of rigour in carrying out comprehensive assessment and following through on decisions.

10.3.4 There is evidence of good practice: for example, during the period of registration in 2002, the social worker did pull together all of the information from the police files and the previous allegations and evaluate these with the team manager. However, the lack of any apparent coherent theoretical and research basis for analysis meant that this information did not lead to protective action. Instead, it led to a failure to properly protect the children as it was concluded that there was “a perceived risk based on the history but no current evidence to support continued Child Protection Registration or Court action.”

10.3.5 This conclusion and assessment of risk is difficult to understand. At this point the risk assessment was incomplete as child 2’s family had not co-operated, and nothing had changed in terms of the risks identified at the initial conference. Mr and Mrs A were still in contact with the children. The previous allegations from child 1 might better be described as unproven, in that they had never been properly or fully investigated, rather than unsubstantiated, as stated in the social care records, and they were not retracted. This use of language is very significant both in the message to children and in the expectations of professionals, as use of the term ‘unsubstantiated’ could be seen as implying that they were untrue.
10.3.6 It is concerning that the subsequent review child protection conference was able to de-register the children in March 2002 without being fully up to date on the situation. It is not clear why full information was not made available to the conference.

10.3.7 In October 2002, when child 2 made a disclosure to a child advocate, the guidance at the time stated that:

“The initial assessment by the social services department of all children in need – whether or not there are child protection concerns – should be completed within a maximum of seven working days of the referral.”

The delay of five weeks before any action was taken was not in line with the guidance. However, after the initial delay these allegations were then responded to quickly and in accordance with child protection procedures at the time.

10.3.8 There were failures to properly apply the child protection procedures or to inform action with knowledge about the impact of sexual abuse on children and therefore the likely impact of delay in interviewing witnesses. This can and did result in retraction and in potential evidence being lost, and also, crucially, there appeared to be little understanding that contact with the alleged perpetrator is likely to place the child at further risk and to increase the chances of retraction. Where this was recognised, there was insufficient action when plans and agreements were blatantly breached and the courts were not used to test out the evidence even when legal advice was that the threshold for court action was met.

10.3.9 When child 2 made allegations that raised concerns for child 3, there was no medical or interview of child 3, despite concerns being raised by her school about ‘sexualised behaviour’. Child 3 was at this time very young, and whilst it would not have been possible to interview her formally to obtain evidence for a criminal prosecution, it would have been possible to find out from her via play, what was happening to her in her day to day life, and to give her an opportunity to tell workers whether anyone was hurting her, and how. This was not done and the indicators of potential sexual abuse were not explored and used to take effective protective action in respect of her.

10.3.10 Again, in 2006, when concerns were raised by a third party, there was a delay of over six weeks before that person was seen and interviewed and eight weeks before child 3 was seen. This was entirely in breach of child protection procedures and good practice guidance.

10.3.11 There is evidence from the Education IMR that the schools involved with the children, in as much as records still exist, did in the main follow procedures at the time and made appropriate referrals to CSC when allegations were made and concerns arose. Unfortunately child 3 moved school in the latter stages of her child protection registration and there was then a lack of active participation in the core group and conference process. Other than this the IMR author rightly points out that there is evidence of much good practice by the various schools involved.

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9 Working Together to Protect Children, DOH, 1999 para 5.13)
10.3.12 Both schools attended by child 2 appear to have “provided a supportive and caring environment for child 2. She felt safe enough to make disclosures to trusted staff and they responded to these promptly and appropriately. Records for child 2’s time at her last school do not allow firm conclusions to be drawn but again this appears to have been a setting in which she felt able to make a disclosure and where that disclosure was responded to appropriately”.

10.3.13 Child 3’s first primary school was proactive in identifying, recording and reporting instances of her inappropriate sexualised behaviour and appeared to understand that this was of concern and not within the realms of ‘normal’ behaviour for her age. They were subsequently actively engaged in the multi-disciplinary safeguarding processes. It is unfortunate that she was subsequently moved to another school which was less diligent in this regard.

10.4.    Was appropriate action taken when it became apparent that plans were not being adhered to and the risk of harm was increasing?

10.4.1 There were three periods of child protection registration where plans were made by Nottinghamshire CSC to protect the children from potential sexual abuse by Mr A.

10.4.2 The first sexual abuse registration was in July 2001 in relation to child 1 and child 2 when the plan had as its stated overall aim, ‘to gain an increased understanding of the sexual risk to the children’. It contained several recommendations, including:

- A core assessment to be completed
- The social worker to undertake direct work with the children
- Legal advice to be taken regarding moving forward with the work should there be a refusal to co-operate.

10.4.3 The County CSC IMR author points out that the plan was vague and did not clearly identify outcomes. This focus on outcomes was not evident nationally at that time, but it would be reasonable to expect a focus on risks and what would need to happen for the children to be safe. As this was lacking, the plan was doomed to fail. The overall aim of a child protection plan as identified in the June 2001 Nottinghamshire ACPC inter-agency guidance was to:

- identify risks of significant harm to the child and ways in which the child can be protected through an inter-agency plan based on assessment findings
- establish short-term and longer-term aims and objectives that are clearly linked to reducing the risk of harm to the child and promoting the child’s welfare
- be clear about who will have responsibility for what actions, including actions by family members, within what specified timescales and
10.4.4 The actual plan gave a lack of clear direction to the core group and to the assessment and was not SMART and measurable. Unfortunately this lack of clarity and strong direction then became a feature of this whole episode of registration.

10.4.5 The child protection plan continued to be undermined and there appear to have been no serious attempts to enforce its provisions and when it was not possible to enforce, to consider and take legal action. Consequently little progress was made with the assessment. Where so much of a CP plan is not being implemented an early recall of the conference would have been appropriate, at which preferably clear legal advice would be given. However, this did not happen, and the first Review Child Protection Conference (RCPC) held in September noted the lack of progress, but does not seem to have resulted in any robust challenge to CSC about the need to more actively seek compliance.

10.4.6 Neither of the children were permitted to see social workers outside of their homes. By November 2001 attendance at the core group had tailed off and the case seemed to have lost any urgency or priority in terms of risk management.

10.4.7 In 2001 child 2 went to live with her boyfriend and his mother, and repeated her previous allegations but said that nothing had happened recently.

10.4.8 The IMR author states that the records indicate that SSD did believe child 2. There was a meeting with a senior manager to consider legal action, but this resulted in written warnings which were not enforced when they continued to undermine the assessment and the child protection plan.

10.4.9 The County CSC IMR goes on to explain in some detail the discussion that then took place between the social worker, the Team Manager and on occasions, the Service Manager and it is clear that the matter was appropriately escalated to a senior manager and legal advice was taken. In January 2002, a decision was taken to consult a psychologist about the case prior to taking court action. The emphasis of the discussion was very much on the “the lack of any hard evidence of sexual abuse”.

10.4.10 By the time the children were deregistered in March 2002, there had been a significant change in the position of CSC, as the IMR author notes:

“It was concluded that there was a perceived risk based on the history but no current evidence to support continued Child Protection Registration or Court action. The emerging view from CSC was that the children should be de-registered, that child 2 should become a ‘Child in Need’, with the offer of a family support worker”

10.4.11 This was a huge turnaround in perspective and it is of concern that this was not apparently challenged by the Chair or the other professionals present at the Review Conference, despite the fact that there had been no co-operation with the child protection plan and nothing had changed to increase the level of protection to
the children. Indeed the assessment of the social worker acknowledged that the ‘children remain vulnerable and there is at least a perceived risk’. As the IMR author states, “In essence, the professional understanding and assessment of risk of sexual abuse to the children had not progressed since the ICPC.”

10.4.12 During this period there was also on-going social work intervention with one of the children due to disability. In August 2001 this child was noted as having bruises due to ‘fitting’. There was no recorded evidence at the social worker’s subsequent home visit of any child protection follow up or enquiry into the bruises. The issue of Mr and Mrs A’s contact with the children remained unresolved.

10.4.13 The County CSC IMR catalogues the discussions within County CSC about the level of risk and the rationale for issuing court proceedings or not doing so. Reference is made in the IMR to the prevailing court judgements at the time - the ‘cogency’ principle in Re H (Minors), (Sexual Abuse: Standard of Proof) (1996) AC 563; (1996) 1 FLR 80; namely, that the more serious the allegation the more cogent must be the evidence to establish that it had occurred. This court decision was indeed hugely influential nationally in discussions in the press about the level of proof required within care proceedings and the difficulties in obtaining ‘findings of fact’ in relation to sexual abuse in care proceedings. It is highly likely that this influenced consideration of what ‘hard evidence’ might be required and was hugely undermining of professional practice. This would have to have been forensic evidence that directly linked the abuse to an abuser – something that the literature at the time clearly pointed out to be extremely unlikely and elusive in most sexual abuse investigations (see lessons learned section).

10.4.14 The IMR also refers at a later point to the policy within the department at that time to reduce the numbers of children who were in care. This may well also have provided a context to the discussions about difficulties in securing care orders, and provide some explanation about why this was not pursued and is further explored later in this report.

10.4.15 However, there is no explanation of the failure to proceed with consultation with a psychologist, given the clear difficulties being experienced by the social worker, team manager, and service manager in determining the best course of action given that child 2 was now refusing to discuss the allegations further and the assessment had in their view produced nothing of value in terms of ‘hard evidence’.

10.4.16 This period of registration ended in March 2002.

10.4.17 The second period of registration took place in November 2002 following further allegations by child 2 resulting in child 3, 4 and 5 being made the subjects of Child Protection Plans under the category of sexual abuse.

10.4.18 By the time of this initial child protection conference there had been further incidents of sexualised behaviour observed in child 3 who was now known to be in contact with Mr A. It is therefore strange that there was no recommendation relating to a medical examination of the child, given that none had taken place.
Within six weeks of the conference there were two reports of the children having contact with Mr A.

The first Review Child Protection Conference in May 2003 agreed to continued registration and noted:
- Child 2’s recent credible allegations - despite the police deciding the previous day no longer to pursue criminal enquiries;
- Child 3’s continued sexualised behaviour;
- The inconclusive police investigation into Mr A which did not definitely exclude sexual abuse, on the civil law ‘balance of probability’;
- The continued contact that Mr A was having with the children.

However, the conference failed to put together a proactive plan that would address these issues and deal with the risks to the children. There should at this point have been a consideration of court proceedings given the continued contact with Mr A, but instead the plan seems to have focussed on continued monitoring. Despite Mr A’s lack of co-operation, no assessment of risks posed by him was completed.

The police IMR sheds some light on this in that: “The decision from CPS (in February 2003) not to support a prosecution is of great significance in this review. The subsequent actions or inactions placed the children at continued and further risk of harm. This was a missed opportunity by agencies to provide better outcomes for child 3 and child 5”.

Certainly given the conversations documented in the County CSC IMR about the ‘burden of proof’ and lack of concrete evidence, the refusal of the CPS to prosecute would have been a real blow to the child protection professionals who may have been counting on Mr A’s conviction to lend weight to the child protection plan. However, this was hugely magnified for the children who would now have had the power of Mr A confirmed and any hope for change ended. The experience of the children as victims would have been strengthened and the professionals now failed to take this into account in their planning, which should have been robust and challenging.

In April 2003, CSC considered issuing proceedings when they became aware that Mr A was still having contact with the children. A Service Manager advised the team manager to get legal advice, but also suggested that the social worker should try and get the parents to sign an agreement prohibiting Mr and Mrs A’s contact with the children, rather than removing them. The legal advice was taken and County CSC went to the lengths of arranging foster placements for child 3 and child 5 in anticipation of their possible removal from their family.

However, child 3 and child 5 were not removed, but instead a written agreement was signed to keep the children away from Mr A.

I have to concur with the analysis of the IMR author at this point:

“…the CSC decision to proceed with an agreement and not seek to remove the children was, in all of the extant circumstances, not a defensible course of action
and did not safeguard and promote child 3 and child 5’s welfare. Moreover, there was no clear and transparent record of decision making or rationale on the file accounting for the course of action.”

10.4.27 The outcome of this approach was that the safeguarding of the children was totally undermined and the child protection plan became totally ineffective. Further breaches of the plan followed and were discussed in supervision between the social worker and the team manager, but this did not result in any action and the report to the next review conference did not mention them.

10.4.28 The July 2003 review conference therefore did not have accurate information from the social worker about the level of non-compliance and although the Chair correctly questioned the fact that Mr A had not been formally advised by CSC about not having contact with the children, de-registration of child 4 and 5 was agreed with a plan for further monitoring of child 3.

10.4.29 There was no paediatric assessment of child 3 and at no time were care proceedings again considered despite the obvious breaches to the written agreement.

10.4.30 The inadequacy of management oversight and protective drive for the case is evidenced by the fact that there were then no core group meetings for a period of seven months, and child 3 was then deregistered in June 2004, with the case being closed a week later.

10.4.31 The final brief period of registration in 2006 was actually protective in that it culminated in child 3’s welfare being appropriately secured.

10.5. What were the circumstances leading to the making of a court Order in respect of child 3 in 2001?

10.5.1 Child 3 had been placed on the child protection register under the category of neglect, shortly after her birth. She was deregistered in 2000 as there were no further concerns at that time.

10.5.2 Within this context, in December 2000 City CSC was directed to prepare a report to assist the family court in connection with an application for a Residence Order on child 3.

10.5.3 The hearing was scheduled for February 2001. The notice from the Legal Officer for Nottingham City Council to the social worker got lost in transit (City CSC IMR); consequently a request was made for an extension of six weeks whilst the report was prepared. Leave was granted for an extension until the end of March 2001 and it was actually filed two days before the due date. In the court report the social worker stated that the case had been allocated to him at the beginning of March 2001.

10.5.4 This author has not had an opportunity to read the court report, although the City CSC IMR author has done so and has provided a helpful analysis which informed this report. The social worker who wrote the report has left the
employ of the City CSC and it has not been possible to track him down for interview. The lack of case notes for child 3 already referred to in the previous section also seriously limited the amount of information available and therefore the depth of analysis that is possible.

10.5.5 Both the City CSC and the Education IMRs report conversations with the social worker in which they raised concerns about contact between child 3 and Mr and Mrs A. Both of these conversations appear to have been instigated by the professionals concerned, and not by the social worker as part of a multi-agency assessment for the report.

10.5.6 It would appear at this time that the health visitor was worried about contact with child 3 by Mr A and spoke with the social worker at length. The health visitor was advised that these concerns would carry little weight as the allegation by child 2 had been retracted. The City CSC author feels that it is possible the health visitor felt disempowered by the court process and other then sharing this concern, she could do no more.

10.5.7 The conversation with the school was prompted by the allegation of sexual abuse by child 2 against Mr A in March 2001, discussed with the social worker by the school in April 2001. He was therefore well aware of the context of concerns for child 3, but this was not mentioned in the court report.

10.5.8 The police have no record that they were contacted in line with protocols at the time to seek their views on the application as part of the report writing process. The City IMR author states that:

“From the report it is evident that the Social Worker had access to the previous assessments undertaken and liaised with the Social Worker involved with child 1. The court report was superficial and had limited analysis which is likely to be a result of the short timeframe between the worker being allocated the case and the report needed filing. The Social Worker briefly mentioned the sexual abuse allegations made by child 1 and 2, reporting that all allegations were retracted (this was inaccurate as child 1 never retracted her allegation) and no further Child Protection or legal processes were followed. ……………”

10.5.9 Given the information already available and the active allegations from child 2 at the time of the Hearing, it is very difficult to understand why these matters were not presented robustly to the court. This is even more concerning when one considers that the social worker had significant background information about the case. There is also a notable absence of management oversight, although the absence of any file for child 3 makes it impossible to take this analysis further.

10.5.10 The Guardian Ad-Litem appointed by the court to ensure that the child’s interests are paramount in any proceedings no longer works for CAFCASS and it has not been possible to track down the notes from the period in question..

10.5.11 An Order in respect of child 3 was granted in April 2001 which effectively supported her residence in a location that placed her at risk of sexual abuse. One can only conclude that City CSC failed in their duty of care to child 3 to bring to the attention of the court the historical and current concerns about sexual
abuse which may have prompted a more in depth and appropriate consideration of child 3’s future.

10.6. **Were there any racial, cultural, linguistic, faith or disability issues that needed to be taken into account in the assessment and provision of services? How were these issues managed by each agency?**

10.6.1 All of the subjects of this review were of White British heritage whose first (and only) language as far as is known was English and it is not known if there was a religious or faith element to their lives. The children suffered from deprivation and neglect and were all vulnerable. Given the information available from the IMRs, if one accepts the definition of ‘culture’ as being “the ideas, customs, and social behaviour of a particular people or society” then the culture to which the children were exposed was closed and tightly controlled by Mr and Mrs A. The children were not valued for themselves and were not allowed to talk to professionals about their lives. The adults used the children to their own ends. They moved address many times. The children were neglected and hit and the older siblings were used to look after the younger ones. Practical living standards were poor and their homes often smelled of urine. Adults were not in employment and education was not particularly valued and the children were not encouraged to have aspirations of their own. Child 2 also describes frequent vocal and violent arguments, fuelled by alcohol. It is unfortunate that this cultural description of the children’s homes did not form the basis of a core assessment at a time when the children could have benefitted from protection and nurture.

10.6.2 One of the children was a disabled child and had various injuries which were accepted as being as a result of disability, with no investigation despite child protection concerns being raised. When the child displayed sexualised behaviour and distress when being taken to the bathroom in respite care, the parental explanation appears to have been accepted without question despite the context of sexual abuse allegations in relation to Mr A who had continued contact. It remains unclear whether this lack of enquiry was influenced by attitudes to disability.

10.6.3 The multi-agency Child Protection procedures in effect at that time specifically stated that, “Disabled children may be especially vulnerable to abuse… Particular attention should be given to helping the child to communicate and to how the disability may mean additional vulnerability for the child.” Despite this there is no evidence of the child ever being specifically asked about the injuries or being considered for interview when allegations of sexual abuse were being made by child 2 in 2000 nor in 2002.

10.6.4 The procedures reflect the fact that there had been significant research into the abuse of disabled children, and as far back as the late 1980s the issue of the sexual abuse of children and adults with learning disabilities was more fully

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10 Oxford English dictionary
11 Inter-agency guidance on the Assessment of Children in Need, and the ACPCs Child Protection Procedures, Nottingham City and Nottinghamshire ACPCs 2001 Chapter 4, Section 5 p14.
recognised (Brown and Craft, 1989). This led to further research and publications (Kennedy and Kelly, 1992) including pioneering work interviewing disabled children who had been abused (Marchant and Page, 1992; 1997) although the Memorandum of Good Practice on Video Interviewing with Child Witnesses for Criminal Proceedings itself said little about interviewing disabled children. The Department of Health then produced an excellent detailed training and good practice pack (ABCD Cross et al.1993 NSPCC) and this was launched nationally and advertised to all local authorities.

10.6.5 Alongside the publication of The Framework for the Assessment of Children In Need and their Families, in 2000, specific guidance was produced by the Department of Health (Marchant and Jones, 2000) in respect of assessing the needs of disabled children and their families.

10.6.6 Sullivan and Knutson (2000) found that children with impairments were 3.4 times more likely to be maltreated than those without and showed that most disabled children who were abused endured multiple forms, neglect being the most common. The research literature indicates three main categories of increased vulnerability for disabled children (Miller 2003): the attitudes and assumptions held by others; inadequacies in service provision and factors associated with impairment.

10.6.7 Negative attitudes in society create both a vulnerability to abuse and make it less likely that disabled children will be listened to about their experiences of abuse. This is compounded by a lack of awareness among carers, professionals and the general public of the vulnerability of disabled children. The indicators of abuse are sometimes mistaken for the effects of impairment. There is still a commonly held belief that disabled children are not abused and this can lead to denial or failure to report abuse.

10.6.8 Edwards and Richardson’s exploration of the systems and procedures in place revealed many barriers to identifying and protecting disabled children from abuse at all stages of the child protection process (NSPCC 2003). Disabled children were often left in situations with a high level of neglect, and sometimes abuse, because a professional felt the parent, carer or service was doing their best in difficult circumstances. This seems to have been prevalent in this case.

10.6.9 The police IMR author has identified areas of learning in respect of the way in which agencies approached the issues of disability and also gender. She notes that the two male children “never made any disclosures of sexual abuse but were placed on the child protection register under the category of sexual harm… which was safe practice. However, there did not appear to be a real consideration from professionals as to whether or not they were equally at risk of sexual harm as male children”. Information that one of them had been groomed by a schedule one offender from prison and subsequently lived with a high risk sexual offender for six months was never given any weight in the deliberations of risk, suggesting a failure to understand the vulnerabilities of male children to sexual abuse and exploitation.

10.6.10 The acceptance of Mrs A as a non-abusing partner of Mr A despite the statements of both child 1 and 2 which implicated her in the abuse also suggests a gender bias present in all agencies which then worked in her favour. The police IMR
points out that: “This could be partially attributed to the low or non-existent profile at the time of women who sexually abuse.” The City CSC IMR also picks up this issue but it does not appear to have been considered by any of the professionals at the time.

11. Lessons Learned

11.1 The review has identified a number of key themes in relation to practice which it is important to further explore and which I seek to address in my recommendations.

11.2 The first concerns the voice of the child and how this was not clearly heard and understood throughout the period of the review. Unfortunately, this is an all too common theme in serious case reviews. The voice of the child and their experience was given insufficient weight as evidence by professionals in this respect. In the vast majority of sexual abuse cases this is all there will be, together with risk factors informed by research evidence. This is rarely enough for criminal prosecution to be successful but should nevertheless inform other protective measures for the children concerned.

11.3 This can first be understood in the way in which the children’s statements, allegations, and retractions were viewed and the impact this had on decision making. It does seem that retractions were more likely to be believed than statements and allegations of abuse, and there was some confusion about the balance of proof required to act at various points. The search for ‘hard evidence’ referred to in the county social work files and referenced by the County CSC IMR, undermined child protection planning and protection for the children, and intervention by the family court was not sought at key points, despite ample ‘evidence’ which could have been placed before it which, in the view of their own legal department, met the threshold for proceedings. The voice of the child and their experience was given insufficient weight as evidence by professionals in this respect. In the vast majority of sexual abuse cases this is all there will be, together with risk factors informed by research evidence. This is rarely enough for criminal prosecution to be successful but should nevertheless inform other protective measures for the children concerned.

11.4 Child 2’s allegations were disbelieved because she retracted them at various points, and child 1 stopped co-operating when her account had some inconsistencies. She at no point retracted her allegations however.

11.5 Both city and county CSC IMRs and the police IMR acknowledge that the approach to the children’s allegations was not always helpful, and that for child 1, this went as far as undermining their story and conveying a level of disbelief which resulted in them clamming up. Professionals do not appear to have considered the impact of the children’s contact with Mr A and agency delays in progressing investigation as being significant in the children’s subsequent unwillingness to proceed and in this respect failed to protect the children.

11.6 Both child 1 and child 2 were then permitted to place themselves at risk – sleeping rough and being offered no assistance other than being taken back into what they perceived to be impossible circumstances. This would have confirmed the

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12 Brandon et al Biennial Review of Serious Case Reviews 2007 - 9
13 NSPCC Consultation 2011
children’s views that they were worthless and that everything that was happening to them was their fault – a point that many abusers are happy to make and to have confirmed.

11.7 Given this it is hardly surprising that victims find it hard to tell anyone. NSPCC research shows that 72 per cent of sexually abused children did not tell anyone about the abuse at the time, and around a third still had not told anyone about their experience by early adulthood (Cawson et al 2000).

11.8 Both child 1 and child 2 found themselves not being believed even though research suggests that very few children lie about sexual abuse (Tully 2002). Davies and Westcott’s (1999) research review of interviewing techniques found that children who were suspected of lying rated it a very stressful event and many abused children have reported that their fear of not being believed discouraged them from disclosing. Stress does not automatically negatively affect memory, but being stressed may make it more difficult for children to recall information.

11.9 The County CSC IMR makes reference to the early research by Summit (1983) which identified a pattern of behaviours known as the child abuse accommodation syndrome. Summit argued that while children who have experienced sexual abuse may tell others about it gradually or incrementally, many children remain silent about it, deny that it actually happened, or produce a series of disclosures of abuse followed by recantations, as was the case with child 2.

11.10 Retrospective studies of adults highlight the factors that appear to influence this, such as the age of the child when the abuse first started, the child’s relationship to the perpetrator; the nature and context of the sexual abuse, the use of threats, bribes or physical force which all affect a child’s willingness to disclose abuse in the first place and may well influence their decision to deny or retract subsequently (Alnock op cit). Thus long-term abuse that starts at a very young age may be the type of abuse that is the least likely to be disclosed.

11.11 Allegations of sexual abuse made by children are frequently challenged and contested; if the child is not supported there is a strong possibility that the child will withdraw them. Retractions may be genuine efforts to set the record straight or they may result from the victims desire to avoid the consequences such as the intervention of police and child protection services, the disruption of family life, or cultural and family pressures. Tully suggests that incidents of retraction should be fully investigated and recommended two techniques, a videotaped Memorandum of Good Practice interview and a statement validity analysis.

11.12 When child 1 made their initial allegations, they should have been offered a video interview and the police IMR author was unable to comment on why a video interview was not conducted with child 1 on this occasion as the rationale was not recorded. It may be that this was the choice of the child or there were not the appropriately trained staff available. The interview was undertaken jointly by police and a social worker and was done by way of taking comprehensive written notes to be transcribed into a written witness statement. The interview was conducted over two days. Not undertaking a video interview made this a lengthy process for child 1 and the professionals involved. Child 1 was repeatedly asked
about things they had said, and there is evidence from the social care IMR that the social worker had already formed a view that they were fabricating. It is unsurprising that the child then ‘clammed up’.

11.13 Many studies have identified the police stage of investigation as the key point of attrition for a majority of sexual and child abuse related crimes in the UK criminal justice system (NSPCC consultation 2011). Cases can remain undetected for a variety of reasons, such as there being no identifiable offender, the victim denying or retracting an allegation, the victim refusing to co-operate with the initial investigation or withdrawing at a later stage. Further points of attrition occur when moving from the detection to the prosecution of crimes and from their prosecution to conviction. Here the NSPCC research (op cit 2011) shows that very low numbers of individuals prosecuted for the rape or attempted rape of a child under 16 received a conviction for reasons including insufficient evidence and doubts about the credibility of a child’s or witness’s evidence.

11.14 The police IMR author acknowledges the huge impact on child 2 of the CPS decision not to prosecute Mr A in 2003. The author explains that one of the reasons for the CPS decision “was the likelihood that child 2 would experience a gruelling cross examination that could be detrimental to their emotional and mental health” She acknowledges that child 2 was not consulted about this decision and there was no consideration given to the negative impact that it would have on them. The IMR goes on to point out that there is a growing acceptance that victims of child abuse and domestic abuse do not make the ‘perfect’ witnesses and allowances are now made for this. Victims are now given the opportunity to speak with the CPS regarding decisions that are made in relation to their cases and in that respect have a greater voice. Achieving Best Evidence already affords vulnerable and intimidated witnesses extra protection in court cases. There are proposals for the future that the cross examination of vulnerable and intimidated victims and witness will also be pre-recorded in a visually recorded cross examination.

11.15. Whilst this refers specifically to those occasions where there were allegations to be investigated, the underlying issue highlighted throughout this review is about the need to ensure that the voice of the child is the central focus of all child protection work, and that those who carry out this work have the skills and support necessary to talk to children of all ages and in very difficult circumstances. Non-verbal children and babies can also communicate and it is the responsibility of child care professionals to understand what non-verbal children’s behaviour may be telling them and to access specialist advice when they need it. Child 3 as a toddler was exhibiting highly unusual and sexualised behaviour and child 5also did this at key points, yet neither of these children appears to have been given the opportunity to communicate about their daily lives and to make sense of the things that were happening to them – good and bad. Their voices were not heard.

11.16 This cannot always be the role of the social worker and it is important that there is a separate advocate for the child, who is not part of the alleged abusers sphere of influence. The child’s voice was also not apparent in the child protection conferences and was not clear in the IMRs for the review.
11.17 Although attempts were made to access the children’s wishes, this was sometimes ill informed. For example, the child protection conference held in June 2004 made a decision to deregister child 3 which was based on a flawed assessment and a lack of progress. The school attended and the teacher at child 3’s school described her poor concentration at school and good communication and peer relationships. She told the meeting “child 3 (sic)…..would tell someone if she was unhappy ‘and discuss any problems she had’}. However, as the IMR points out, child 3 had only been at this school for two months and the teacher would not have known them very well, yet this does not seem to have been challenged by the conference chair, and was accepted as a reflection of the child’s voice. It presented a contrary view to that given by child 3’s previous school, where the child was well known and there had been several concerns raised by her teachers.

11.18 Whilst there are child advocacy services for children in Nottinghamshire who are subject to child protection conferences these tend to be ‘opt in’, that is, the child is given the offer of an advocate and this is often not taken up. Research\textsuperscript{14} and experience tells us that children’s participation at such meetings is significantly strengthened when an advocate is provided as a matter of course, and the child has to ‘opt out’ and say that they do not want one. Where the matters being considered are so complex and involve a child’s disclosure which has been denied by the care giver, it seems sensible for the child to have access to an advocacy service which will represent their views and wishes to professionals, rather than leaving this to the social worker who is also working with the alleged abuser(s) or non-protective care givers.

11.19 It is heartening that the City CSC IMR outlines a change in service for children in this respect and that sexual abuse cases can now be referred to the NSPCC for an assessment which is impartial and separate from the allocated social workers responsibilities.

11.20 The next lesson relates to the apparent absence of any coherent and consistent theoretical model or framework for understanding and managing risk in sexual abuse until the final period of registration in 2006. The research mentioned above and in this section, and the frameworks for managing abuse which are referenced in this report were all available at the time and played a significant part in the development of national policy and practice guidance. There is evidence from the IMRs of individual professionals and social workers using some of the information from Finkelhor for example to inform assessment, but this is not the case when discussions with senior managers are reported, and there is certainly no evidence of this within any of the Child Protection conferences as reported in the IMRs. As Susser\textsuperscript{15} states:

“To practice without theory is to sail uncharted sea: theory without practice is not to sail at all”

\textsuperscript{14} http://www.ncb.org.uk/media/898464/involved_by_right_research_report_final.pdf
\textsuperscript{15} Susser in Hardiker and Barker 2004
11.21 Good social work theory draws upon the real life experiences of survivors and in sexual abuse, by the late 1990s also drew upon the testaments of convicted sexual offenders, as gathered and publicised by the Gracewell Clinic and other treatment programmes at that time. Use of such information would have enabled the professionals to clearly identify the strategies being used to such effect by Mrs A and Mr A to undermine professional intervention and would have put the children’s retractions and behaviour into a more coherent and evidenced framework.

11.22 This absence of theoretical framework and research is tacitly acknowledged by the IMRs for Nottingham City CSC, Nottinghamshire County CSC and Nottinghamshire Police who reference the training and development programmes rolled out already in these organisations since 2006 to put into place a more in depth understanding of the cycle of abuse and power position of abusers within family, community and professional networks. For City CSC this includes the provision of training by the Lucy Faithful Foundation (formerly Gracewell Clinic). They also reference training which is being commissioned currently, and describe many changes in their organisations which are aimed at addressing this issue and ensuring that staff are properly trained and managed.

11.23 The County CSC IMR author also highlights the development of inter-agency practice guidance on assessments and partnership working which includes when to commission specialist assessments for instances such as when a child is showing sexualised behaviour. Multi-agency practice guidance on the Sexual Abuse of Children and Young People was jointly published by the Nottinghamshire and Nottingham City Safeguarding Children Boards in October 2006. The City CSC IMR states that this guidance is currently under review and findings from this SCR should feed into the review process. The Guidance does include reference to evidence based approaches but now needs to be finalised and implemented. It does not reference the status of the research evidence which supports it, and could usefully be clearer about the requirement to reference this in assessment and planning.

11.24 The County CSC IMR recognises that training in itself will not change practice and protect children effectively. The evidence of successive serious case reviews is all too clear in this regard. The IMR author therefore stresses "the need for robust systems of audit and quality assurance of supervision that can demonstrate effective and reflective management oversight of safe social work practice in the safeguarding of children and young people." This is a key requirement for a safe and effective ‘child centred system as set out Professor Eileen Munro’s review of child protection practice published in 2010.\textsuperscript{16}

11.25 I agree with this view and also that the use of research and theory, like training, will not change outcomes for children, and as discussed by the Panel in the preparation of this report, neither will the range of protective actions available to professionals, unless they are prepared to use them. For example, the PLO\textsuperscript{17} route now must be followed by professionals where parents are failing to keep to agreements and proceedings are possible as a result, thus making the opportunity

\textsuperscript{16} The Munro Review of Child Protection: Final Report a Child Centred System 2010

\textsuperscript{17} Public Law Outline (PLO) 1st April 2008 aims to improve the timescales in which decisions affecting children are made
for repeated breaches of agreement without escalation to court less likely. However, for this to work a professional must recognise the need for it and implement the procedure. There were already effective mechanisms for protecting children prior to the PLO but they were not used in this case, which relates to the third and most significant lesson – the lack of professional curiosity and willingness to intervene and take action – no-one was advocating or championing for these children and driving the case.

11.26 The review identifies some key missed opportunities to take decisive action that would have protected the children and safeguarded their welfare. These include action, or inaction, by the Independent Chairs of the child protection conferences which appears to have been based on acceptance of the lack of progress on the children’s plans and failure to identify plans which were focussed on the nature of risk and the measurable changes required by child protection procedures at the time. The role of the IRO has subsequently been strengthened by the Care Planning Regulations 2012 and they now have more power and responsibly in relation to Looked After Children, but this is less clear in relation to child protection co-ordinators who provide chairing for child protection conferences. Both CSC IMRs contain helpful recommendations and actions in relation to this point, and I understand that the NSCB now audits child protection conferences to identify good and poor practice.

11.27 As previously discussed there were points at which County CSC had clear legal advice that the threshold was met for legal proceedings, yet the decision was made not to proceed but instead to seek further agreement, despite evidence that the adults would not stick to any agreement even if they were to sign it. What is reassuring is that the senior manager responsible for one of these decisions is recorded in the County CSC IMR as having regretted this decision when reviewing the case as part of this review. They concluded that they would have gone for proceedings on the evidence as it stands, were this presented to them today. This is at least heartening as it suggests learning from experience and that other children may receive a more robust and protective response.

11.28 In trying to understand the context in which decisions were made, the County IMR author has explored the culture that existed in the organisation at the time. The author makes reference to the workload pressures within the social care service and states that: “......it is true to say that there was a seven year period when the service had been operating at a capacity which was increasingly unable to cope with work volume, culminating in a DfE Improvement Notice in June 2010.” The issue of case loads and changes of worker will have had an impact on the capacity of social workers to carry out their responsibilities, but this is not specifically explored in the IMR. However research clearly links stress, workload pressures and the application of thresholds to services to the quality of social work assessment and practice – poor practice and outcomes for children being linked with these factors\(^\text{18}\) and this is explored in detail in Professor Eileen Munro’s review of child protection in 2010\(^\text{19}\).

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\(^\text{18}\) Social Work assessment of children in need – what do we know? Turney et al, University of Bristol, School of Policy Studies 2011

\(^\text{19}\) The Munro Review of Child Protection: Final Report a Child Centred System 2010
11.29 It is important also to note that there were many changes of social worker and team manager through the life of the case - the County CSC IMR catalogues 13 social workers, some of whom were involved for short periods of time, plus 6 team managers and four different service managers who made decisions about the children’s lives, as well as other family resource staff who were involved at different times. Additionally, not all of the transitions between workers were handled well and there is evidence that the momentum was lost at key decision points when there were opportunities to intervene and to safeguard the children. The responsibility for maintaining an overview, particularly of such complex cases, rests with managers, and the County CSC IMR author concludes that “It was a shortfall of collective poor management practice; rather than, necessarily, poor Social Work practice that resulted in these opportunities not being taken.” He then makes a number of recommendations to seek to address this shortfall. However, the practice of some of the workers is questionable and this is being addressed by the departments responsible.

11.30 The County CSC IMR also identifies a prevailing culture in the department of avoiding the removal of children into care and indeed the County was known to have fewer children in Care than any of its comparator counties at that time. “Until 2009 Nottinghamshire had very low rates of Looked after Children, compared to the local authority’s statistical neighbours and the English average. Figures provided by the current Nottinghamshire CSC Service Director (SD1) show that between 2004 to 2009 the LAC rate per 10,000 was between 28-30 (29 in 2004). Figures were not kept by the local authority before 2004, but it is a reasonable assumption to make that the figure for 2003 was of a similar magnitude, namely around 28/29 per 10,000. The corresponding figures for statistical neighbours and England were in the range of 49-51 and 55 per 10,000 respectively during 2004-09. Thus it can be seen that the Nottinghamshire CSC LAC rate was around only 58% and 53% respectively of its statistical neighbours and England.” (1.4.5)

11.31 The IMR goes on to state that “The low rates of LAC in Nottinghamshire in 2003 suggest that there was a very high threshold for taking care proceedings and accommodating children and young people…..whilst there was not an explicit ‘No accommodation policy’ the prevailing practice and culture was to find alternatives to care, where possible.” It is unclear whether this was motivated by a financial need to manage the departments’ budget, or a philosophical belief that public care was damaging for children. Regardless of which, the impact would have been that social workers and managers were working with highly complex cases with an underlying assumption that the children would not be removed from parental care unless this was totally unavoidable. This can seriously restrict professional judgement and place professionals and the children for whom they are responsible, in impossible situations, where the threshold for intervention becomes unrealistically high.

11.32 The threshold applied was indeed very high when explored in relation to this case, but the records do not allow interrogation of this ‘culture’ as the rationale for why the children were not removed even when the threshold was met, that is
where it was agreed that “There is reasonable cause to believe that a child is suffering or is likely to suffer significant harm...”\textsuperscript{20} Not to act in the light of this to protect the children could be construed as a failure in the duty of care of the Social Services Department. Why this happened is still unclear. There is no evidence to suggest that any social worker or manager made a decision individually or collectively not to protect children and indeed there is much evidence of individuals doing their best at the time to work with them and to seek advice about how to proceed. There is also evidence of some individual poor practice which was not addressed at the time, although this is not endemic.

11.33 The review has highlighted many failures to act within the context of a highly manipulative abuser, lots of changes of manager and worker, high workload pressures and an organisational culture which did not seem to support active intervention if this was likely to lead to care proceedings. The senior manager drive to keep the numbers of children in care low is highly unlikely to have been motivated by a desire not to protect children but it does appear to have had some unintended consequences in this context. Other factors are likely to have included a lack of management oversight and understanding of the impact of decisions on outcomes for children, but this is not explored in any detail in the IMRs. What these together seem to have amounted to at key points is a lack of passion and drive for the rights of children to be safe and to be happy, and a failure to act in the children’s best interests.

11.34 Some identified failures by other professionals who were not part of children’s social care appear to have been motivated by a lack of confidence in their own judgement and therefore a lack of challenge to the social services department when things were not being progressed. As referenced earlier, this led to a falling off of professional attendance at the core group during the second period of registration and the failure to share information or to recognise its significance at some points. Again, this is a common finding in serious case reviews and is an issue which LSCBs need to address in their learning and improvement frameworks.

11.35 As discussed above the case management appears to have been underpinned an early stage by a belief that child 1 and then child 2 were not telling the truth, and much of the case work that followed can be understood if this belief is applied, even when there was evidence to the contrary. In fact, this view about the children only changed in this case when child 2 demonstrated dogged determination to make her voice heard and to get the police to listen to her. Unfortunately her bravery did not protect child 3 as quickly as she had intended.

11.36 Eileen Munro, states: “The single most important factor in minimizing errors (in child protection practice) is to admit that you may be wrong” (Munro 2008: 125)\textsuperscript{21}. For this to happen requires that “all processes that support and inform practice foster a questioning approach or a spirit of inquiry as the core professional stance of the child protection practitioner”\textsuperscript{22}.

\textsuperscript{20} The Children Act 1989 Section 31
\textsuperscript{22} Turnell, A Signs of Safety, A comprehensive briefing 2010
Social workers do not enter the profession to fail children or to “rush from visit to visit, completing forms and instructing parents (usually mothers) to change their behaviour so that their children do not suffer abuse”\(^\text{23}\). Yet, research into families’ experiences and social work systems suggests this is the reality for many\(^\text{24}\). It is highly unlikely that this experience was any different for the social workers in this case. In order to be effective, practitioners must be supported by their organisations to be resilient confident and knowledgeable, and as Munro suggests to continuously question and reflect on their practice. This requires the embedding of reflective supervision, effective quality assurance and support, and investment in training and development at a post-qualifying level. Both the City and County CSC IMRs have outlined changes in their departments to support this, and this also needs to be a focus of LSCB quality audit.

The current (2013) figures for rate of Looked After Children in Nottinghamshire are 54 per 10,000 compared to the statistical neighbour and England rates (2012) of 58 and 59 respectively and there has been a significant increase in numbers of LAC children in Nottinghamshire from 2009 onwards, to the extent that figures in 2013 are comparable to statistical and national averages. This supports the fact that the culture within the department has changed since the period of this review.

It is also heartening that in 2006, after an initial unacceptable level of delay, decisions and actions made in respect of child 3 were informed by the evidence of an enquiry which was well managed and effective. The assessment clearly recognized the risks to child 3 and their need for protection from sexual abuse. Therefore, the evidence suggests that there was more effective working both by County CSC and in collaboration with other agencies to safeguard and promote child 3’s wellbeing in this more recent period.

The Nottingham City IMR describes the introduction of the Signs of Safety model across agencies to support a more effective child welfare service and Nottinghamshire County is apparently considering the benefits of this approach. The approach builds on the voice of the front line worker and those with whom they work and also seeks to embed the spirit of appreciative enquiry and reflective practice advocated by Munro and others. Both LSCBs will no doubt be closely monitoring the impact of this model on outcomes for children as a potentially positive development in a challenging and complex child protection environment, and there are others which would also bear scrutiny as potentially helpful in delivering culture change.

There was discussion at the Panel about the role of the CPS in the decisions about prosecution and the impact this may have had at various stages. It was noted that the CPS guidelines on prosecuting cases of child sexual abuse have been recently revised and that the revised guidelines give a greater voice to victims within the decision making process around prosecutions\(^\text{25}\). The CPS was not invited

\(^{23}\) Kate Morris, Brid Featherstone and Sue White is professor of social work at the University of Birmingham Guardian Professional 2013
\(^{24}\) As above
\(^{25}\) Interim Guidelines For Prosecuting Cases of Child Sexual Abuse, Director of Public Prosecutions, June 2013
to take part in the review and professionals were also mindful of the CPS policy to destroy records after 6 months, which would in any case have made their contribution minimal. Nevertheless, it would have been preferable to engage the CPS in the review and this is the subject of a recommendation.

11.42 Finally, this report has made brief reference to the use of language in the case and how this has conveyed professional opinion and may have influenced the course of events. That is, for example, the use of the word ‘fabricating’ in the social work records, and the term ‘unsubstantiated’ which is recorded in the child protection case conference notes. These terms together convey a view that the children’s allegations were not to be trusted and the latter term is used even where professionals did believe what child 2 was saying. Certainly child 2 heard that she was not believed. Similarly, the focus on ‘hard evidence’ referenced in the child protection conference notes and the social work records, seems to have diverted professionals from considering the child’s experience and behaviour as evidence in itself. Professionals therefore need to carefully consider the power of language and the impact this has on professionals practice and judgement, and reference this within a theoretical and practice base which is truly empowering of children and passionate about their welfare. This was sadly lacking at key points in this case.

12 Recommendations

I fully support the individual agency recommendations which are outlined in the serious case review action plan developed as part of the review. The recommendations reflect significant and wide ranging changes which have already taken place in agencies both as a result of national policy and legislation but also as a result of learning from this and other reviews. These in combination suggest a safer process and system for child victims of sexual abuse. However, as this and other serious case reviews demonstrate, practice and system changes are only as good as the determination and professionalism of those on the front line and the people who manage and support them. For this reason Working Together 2013 requires the LSCB to have in place a learning and improvement framework which informs the membership about the real lived experiences of children who are in receipt of care and support. Within this context the Board should review the actions outlined for individual agencies to satisfy itself that practice in relation to child sexual abuse has indeed improved and that children in such circumstances are being adequately protected. I also make the following recommendations for the NCSCB:

1. The Board should liaise with the City LSCB to ensure that they also have an opportunity to evaluate and share the learning across boundaries and to determine what action they will take in response to this report, including the potential value of the signs of safety initiative and other models which promote appreciative inquiry and a clear focus on the voices of children.

2. The Board should satisfy itself that all professionals working to safeguard children have access to up to date research and theory to inform their practice and that this is evidenced in assessment and analysis underpinning decisions about planning, particularly but not exclusively in cases of sexual abuse.
3. The Board should progress the implementation of the working framework to be used in sexual abuse cases, ensuring that it reflects a clear commitment to the research and evidence base underpinning it, including the links between sexual abuse and other forms of abuse such as physical, emotional abuse and neglect.

4. The Board should challenge member agencies to ensure that the voice of the child is clearly evident in every case, and to champion at every commissioning forum the need for the provision of child advocacy at every stage of the child protection process as a right and expectation rather than an exception.

5. The Board should ensure that the role of the child protection co-ordinator as Chair of child protection conferences is sufficiently robust and that there are clear protocols and requirements in place for them:
   a. to challenge the decisions of any agency where necessary;
   b. to call agencies to account where the plan is not being progressed;
   c. to ensure that no child should be removed from a plan where the risks have not been specifically addressed; and
   d. to ensure that the voice of the child is evidenced and recorded.

6. The Board should ensure that the Child Disability Service continues to have effective child safeguards in place and seek reassurance from CSC that cases have been audited to ensure that safeguarding issues are being recognised and acted upon.

7. The Board should clarify the relationship with the CPS. Consideration should be given to obtaining their engagement in serious case reviews as appropriate and a clear process for seeking their views, advice or engagement in the future should be established.

Ruby Parry,
Lead reviewer,
Director of Consultancy
Reconstruct Ltd.
27th November 2013.

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