

FOR PUBLICATION

Executive Summary for Rotherham Safeguarding Children Board in respect of the children of the 'Z' family

1 Introduction

- 1.1 This Serious Case Review was commissioned in December 2005 to review agency involvement over six years with a mixed sibling group all aged under seventeen years in September 2005.
- Some of the children's names had been on the Child Protection Register from March 2000;
 - The children had been subjected to sexual abuse over a period of time and the case gave rise to concerns about inter-agency working to protect children;
 - The Case Review Sub-Committee considered that the concerns had not been acted on appropriately;
 - The case had implications for Child Protection Procedures beyond the handling of the particular case;
 - There were common implications for a range of agencies and professional arising out of the case, and
 - There were lessons to be learned by local agencies.
- 1.2 The Serious Case Review covered agency involvement during the period between 1 September 1999 and 30 September 2005.
- 1.3 Single Agency Management Reviews were completed by:
- Children and Young People's Services.
 - Rotherham NHS Foundation Trust, Rotherham PCT and Doncaster and South Humber NHS Trust.
 - Neighbourhood Services
 - Barnardos
 - NSPCC
 - South Yorkshire Police, and
 - National Probation Service (South Yorkshire)
- 1.4 Members of the Serious Case Review Sub-Committee were:
- Mike Cuff (Chair) (RMBC Chief Executive and Chair Of RSCB)
 - Pam Allen, Head of Social Care, Children and Young People's Services
 - Cath Ratcliffe, Chief Education Welfare Officer
 - Michele Stevenson, Acting Operations Manager
 - John Radford, Director of Public Health
 - Kim Porteous, Designated Nurse, Child Protection Department, PCT
 - Ruth Holmes, Divisional Manager, Probation Service
 - David Radford, Regional Manager, NSPCC
 - Angela Smith, Neighbourhood Manager
 - Sharon Hancock, DS, South Yorkshire Police

- Jim Stewart, Safeguarding Manager
- Advised by Frances Jeffries, Legal Services

1.5 The overview report was compiled by CR Parnell, an independent management consultant for social work services, and who has considerable experience in conducting serious case reviews.

Summary

- 2.1 The subjects of this review are children in a mixed sibling group. They lived with their mother during the period under review. The father of all but the youngest child moved out of the family home in 2000. In 2003, mother began a relationship with a non-cohabiting partner who is now known to be the father of the youngest child.
- 2.2 In October 1999 mother had told a school nurse about sexualised behaviour by her sons towards their sisters. Child Protection procedures were not followed in responding to this referral. The girls were not asked about what had happened and Social Services did not make any of the required checks with other agencies.
- 2.3 In February 2000, mother told Police and Social Services that one of the brothers had been witness to adult sexual activity and had access to adult pornography. The immediate safety of the children was ensured by placement with relatives. Father agreed to leave the family home. This decision involved an assumption that mother was a protective parent, a repeated error of judgement throughout the period under review. The Police did not interview family members and, later in February 2000, a maternal aunt reported that further sexual abuse had occurred. Child Protection procedures were not followed: there was no joint investigation and no medical examination of any of the children as a result of either referral.
- 2.4 An initial Child Protection Conference was held in March 2000 in respect of these children. Their names were placed on Rotherham's Child Protection Register and in total 13 conferences were held in the period under review.
- 2.5 Multi-agency Child Protection planning for the children lacked detail and direction, and the lack of progress in working with their mother should have led to earlier action in respect of legal proceedings. There were reports of continued sexual abuse of the girls by their older brothers, also of domestic violence between mother and her new partner from 2003, and also indications of physical abuse and neglect.
- 2.6 Work with the boys by a specialist project for young people exhibiting sexualised behaviour and later therapeutic work with the girls was made more difficult by the lack of joint investigation of the allegations against the boys by the Police and Social Services which could have led to criminal proceedings against the boys.

- 2.7 The two brothers were both accommodated by the local authority; between October 2001 and November 2003 and from March 2003 and throughout the rest of the review period respectively. Care planning for both boys was inadequate and did not contribute to their Child Protection plans.
- 2.8 Legal proceedings were considered from 2003 but it was only at the end of the period under review that plans to take proceedings were beginning to be put into effect. By the conclusion of the Serious Case Review, legal proceedings had been completed to secure the future of the girls in the family and safeguard and promote their welfare. Involvement also continued to support the youngest boy but agencies had ceased to work with the eldest child who had moved to independence.

3 Conclusions

- 3.1 This Serious Case Review reviewed agency involvement with seven children. This large sibling group had a broad range of needs and exposure to risks which required a co-ordinated professional response, and both parents of all but the youngest child and subsequently the father of the youngest child were resistant to agency involvement.
- 3.2 A large number of staff across all the key disciplines came into contact with the children and their parents/carers. The two sets of child protection procedures in place during this period contained sufficient guidance for staff on how to investigate intra-familial sexual abuse and also abuse by child perpetrators if followed correctly. There were also allegations of physical abuse made in respect of both parents and mother's new partner and domestic abuse of mother by both her partners, circumstances for which procedures were in place.
- 3.3 This Review has highlighted many areas of poor practice, and also poor judgements, in the assessment, investigation, planning and reviewing of services to these children. Improved practice has been noted from 2004 but there were still delays in implementing the necessary actions to safeguard the children.
- 3.4.1 Between 2001 and February 2002, the children's cases were not allocated within Social Services. The Serious Case Review has once again highlighted the importance of:
- compliance with Child Protection and Looked After Children procedures,
 - listening to children especially when they are making allegations of abuse,
 - clear and accurate recording in individual records for each child,
 - timely intervention
 - the appropriate use of authority,

- the exercise of professional judgement, and
- the swift resolution of differences of professional opinion, which can be achieved through line management, the child protection conference and looked after children review processes, or referral to the ACPC Case Review Sub-Committee (now the Safeguarding Board Practice Standards Sub-Committee)

3.5 The Review has also highlighted learning points about the conduct of:

- Investigations under Section 47 of the Children Act.
- Medical assessments
- Assessments of alleged perpetrators of sexual abuse, including the commissioning specialist assessments
- Assessment of the non-abusing parent
- Therapeutic intervention
- Child Protection Conference Recommendations and Protection Planning
- Planning for Looked After Children
- Police involvement in Child Protection Conferences
- Professional Development and Training
- The conduct of Serious Case Reviews

3.6 There have been considerable changes in services for children and young people in the period under review. The Social Services Department restructured and action took place in response to the publication of the Victoria Climbié Inquiry report in 2001 and a Social Services Inspectorate Inspection in 2003. The Area Child Protection Committee was replaced by Rotherham Safeguarding Children Board in December 2004. Also, during the completion of the Review, plans were finalised for the establishment of the new Children and Young People's Services in the Council in October 2005. Rotherham Primary Care Trust has also been restructured in 2005.

3.7 Further action is planned by the Safeguarding Board and member agencies to ensure compliance with procedures and to ensure that services are of a consistently high standard to safeguard children. The Safeguarding Board will monitor and audit action plans drawn up by the individual agencies to ensure that lessons are learned from this case.

4 Recommendations

In addition to the recommendations of the Individual Agency Management Reviews, Rotherham Safeguarding Children Board has agreed the following recommendations:

To All Agencies involved in the Review:

- 1 The Single Agency Management Reviews make recommendations for individual agencies. All agencies involved in this Review must develop their individual recommendations into measurable and achievable points within their agency action plans with appropriate timescales.
- 2 All agencies should de-brief the practitioners and managers involved in this case and consider their individual professional development and training needs, and any other action necessary to ensure safe practice at this time.

To Rotherham Safeguarding Children Board:

- 3 The Safeguarding Children Board should develop standards from the South Yorkshire Child Protection Procedures and also a programme of audits to ensure compliance with procedures.
- 4 The Safeguarding Children Board should review supervision arrangements within agencies to ensure that sufficient scrutiny is given to the quality of safeguarding work.
- 5 The Board must reinforce the need for personalised recording for individual children within all agencies. It should contain sufficient detail and clarity to enable appropriate assessment, planning and review of progress.
- 6 The Board should review commissioning arrangements for forensic psychological assessments in cases of sexual abuse. This should ensure there are routes to refer adult abusers, and where appropriate their partners, for assessment and therapy, without this role falling inappropriately to the children's key worker.
- 7 The Board should commission training for Child Protection Conference Chairs and an audit of chairing practice to ensure that recommendations are clear, measurable and that progress is consistently reviewed.
- 8 The Board will review procedures to ensure that all children of a family, regardless of their register status or their address, are considered at Child Protection Conferences.
- 9 The Board will review the operation of the Practice Standards Sub-Committee to ensure that:
 - action identified to take forward cases of concern is taken at the earliest opportunity or resolution is progressed through the line management of agencies and if necessary, through referral to the Chair of the Safeguarding Children Board and the Executive Director of Children and Young People's Services.

- members of the sub-committee have time to research cases and liaise with colleagues directly involved in case management as well as to attend Sub-Committee meetings.
- the recommendations of the Sub-Committee are consistently reported to the next Child Protection Review where children are on the Register.

10 Full details of all of the adults concerned should be included in invitations to, and minutes of, all Child Protection Conferences.

To RSCB Training Sub-Committee:

11 The Training Sub-Committee will review the learning from this case and ensure that the key messages are included across the multi-agency training programme for 2006-2008.

12 The Training Sub-Committee will commission training for Board members in respect of the conduct of Serious Case Reviews by December 2006.

Rotherham Safeguarding Children Board will monitor the implementation of the individual agency and Board Action Plans to ensure that the clear lessons learned from this Review are widely shared and improvements in practice are maintained.

Jim Stewart, Safeguarding Manager

March 2007

Drawn from the Overview Report by Celia Parnell, Independent Consultant